A mixed methods inquiry into the clinical utility of an expressive projective assessment with individuals experiencing early psychosis

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Dedication

"Consider the con-see.quences" ~ My father

Meaning of 'consequence' is attested from the late 15th century, as a "story that follows and continues after another" (www.etymonline.com)

To my family ~ Salah, Monique & Sari Zafran, for being my ground

From my heart to Batta and Minipök ~ in the subjunctive mode

And to the individuals who permitted me to be and do with them as they experienced slippages of personhood; we grew together

Acknowledgements

"Whatever I understand, I come to understand through the mediation of another"
(Davey, 2006, p.9)

I would like to name the invaluable dialogue and learning that I have shared with my supervisory committee: I profoundly thank Dr. Beverlea Tallant, the content expert, for always opening doors, for setting my feet and interest on this path so many years ago, and for being my teacher in both academia as well as in life. I would not be here without her. I am grateful to my thesis supervisor, Dr. Isabelle Gelinas, for what she has repeatedly called our 'collaborative learning model', her consistent and reliable presence and encouragement over the years, and her trust in my way of doing. Dr. Barbara Mazer has been a grounding and calm presence, and I have appreciated her statistical expertise, her moments of excitement during the project, as well as her subtle mentoring during our conversations. Finally, I wouldn't have managed as well or as patiently without Dr. Steven Jordan, who supported the qualitative aspects of this project, and even more, helped me to name and navigate the ethics and politics of conducting a different kind of study within the Faculty of Medicine.

I would like to acknowledge the following individuals: Ronna Schwartz, occupational therapist and friend, for pointing out the thesis topic that was obviously most meaningful to me. Dr. Howard Margolese, the psychiatrist who encouraged the vulnerable youth in his care to participate in this study. Data collection would not have occurred without his trust in my intentions and abilities. And, the late Ms. Madeleine Shaw, former director of occupational therapy services at the McGill University Health Centre; she was extremely generous in her support of my insistence to continue to juggle clinical and research selves.

Very importantly, my heart owes Dr. Melissa Park, mentor and guide since she came to McGill University, an immense intellectual and emotional debt. Cultivating a lived practice of hermeneutics would have been incredibly lonely without her. I thank Dr. Sara Saunders for the levity that our conversations brought to the immensity of being the first doctoral students at our school to learn and apply phenomenology. A debt also to Elin Weinstein, for texting me every morning while I wrote, reminding me that the centre of the universe lies elsewhere. I recognize Philippe Toutoungi, who read every manuscript, who learnt about philosophical hermeneutics just for me, and whose concise one-liners were always the pertinent heart of the matter. Thank you to Sari Zafran, for editing the video data, and always being proud of his "ph'dding" big sister.

I will always owe all the gratitude in the world to my parents. My father for teaching me to always read the dissident voice, to look at the opposing view, and to consider multiple perspectives before making up my mind; and my mother, for providing me with the life-long embodied metaphor to 'color outside the lines' that others have drawn.

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Abstract

Background: Early intervention aims to detect youth at risk of developing psychosis, which is a core feature of schizophrenia. Detection using genetic and behavioral indicators remains inaccurate, whereas research concludes that subjective, experience-based approaches to detection via phenomenological interviewing are more successful in identifying incipient schizophrenia. However, the ability of youth beginning to experience mental illness to verbally articulate their experience may be challenged by the illness process, the stigma of becoming a psychiatric patient, or for other reasons. Expressive projective assessments use arts-based approaches to create therapeutic rapport, creatively elicit narratives of experience, and facilitate observations of expressive doing. This leads to an understanding of an individual's experience for more accurate case formulation. The Azima Battery is an occupational therapy projective assessment that was designed for use with individuals experiencing psychosis in order to facilitate both modes of communication and diagnosis. The Azima Battery has a standard setup and involves the creation of five objects in three media (pencil drawings, clay, finger paint) followed by open-ended, phenomenological interviewing.

Aim: The aim of this project was to validate and explore the clinical reasoning and utility of the Azima Battery as an activity-based approach to evaluation in early psychosis, in order to better detect incipient schizophrenia and understand the experiences of help-seeking youth aged 15-35. The specific objectives were to: (1) critically review the historical development and interpretive traditions of projective assessments in occupational therapy, (2) review the current scientific and expert evidence for their clinical use, (3) examine the predictive validity of the Azima Battery when used to detect incipient schizophrenia in youth admitted to psychiatric services, and (4) explore and illustrate the use of a hermeneutic phenomenological approach in interpreting the Azima Battery evaluation session.

Methodology: A hermeneutic mixed methods study design was used. To situate the interpretive traditions that underpin the Azima Battery, critical historical and scoping reviews of projective assessments in occupational therapy were conducted, as well as narrative interviews with nine experts about this domain of practice. In terms of validation, retrospective data collection of the medical charts of individuals followed in an early psychosis service between 1997-2011, and having been evaluated with the Azima Battery upon entry to the program, was obtained (N=62). The predictive validity of the Azima Battery case formulation was calculated with respect to long-term diagnosis, and compared to the diagnostic accuracy of the initial psychiatrist's evaluation. In parallel, participant-observation data was collected of Azima Battery evaluation sessions that were conducted in real clinical time with nine help-seeking youth followed by early psychosis services. These were analyzed in two ways: (1) the elements of projective activity performance revealed through descriptive phenomenological analysis (n=9) were nominally quantified and used to code the

productions of the whole sample (N=62). Statistics to explore patterns of performance distinctive of a long-term diagnosis of schizophrenia were applied. (2) Hermeneutic phenomenology was used to interpret and understand the experiences of the nine participants, as well as the structure and unfolding of the evaluation session as a whole. Ongoing reflexive analysis of the multiple research methods and findings was achieved through the use of research diaries and dialogue with a reflection team.

Findings: The critical historical and expert perspectives helped delineate clinical guidelines for use, and revealed the epistemological tensions between the diagnostic and therapeutic aims of expressive evaluations, implying a need to articulate a clinical reasoning language to bridge the divide between these two clinical purposes. With respect to the mental health case formulation, this study demonstrated that the Azima Battery has greater predictive validity than the psychiatrist's initial impression (88.7% vs. 41.9%) in detecting incipient schizophrenia. Combinations of elements of performance distinctive of individual's with incipient schizophrenia lie in difficulties in the structure of their productions. In terms of the hermeneutic phenomenological analysis, a deeper existential understanding is offered of the participants' frozen experience of temporality, tenuous intentional arc and connection to a shared world, and sense of always having been different and liminal. The potential of the clay task to be interpreted as an 'acted narrative' revealed a visual and enacted metaphor of how the participants (n=9) orient to and engage with what they desire most.

Implications: Ongoing hermeneutic analysis of the overall research process raises caution about treating immigration or abuse as static-in-the-past risk factors as opposed to enfolded into the present experience and presentation. Further, this study raises questions about the epistemology and mode of evaluation in early psychosis services, as well as the ontology of psychosis. Implications for occupational therapy clinical reasoning are discussed. The clinical utility and validity of the Azima Battery is demonstrated and proposed as a recovery-oriented evaluation process for help-seeking youth.

Résumé

Contexte: L'intervention précoce a pour objectif de dépister les jeunes a risque de développer la psychose, qui est un symptôme clé dans le diagnostique de la schizophrénie. Les modes de dépistages basées sur des indices génétiques et comportementales demeure inexactes. La recherche démontre qu'une épistémologie intersubjective et phénoménologique dans les entrevues diagnostique est plus précise pour identifier la schizophrénie naissante. Toutefois, la capacité d'un/e jeune de s'exprimée verbalement quand il/elle est au début d'une maladie mentale peut être compromis par la maladie elle-même, la stigmatisation associée a processus de devenir un patient psychiatrique, ou pour d'autre raisons. Les évaluations expressives projectives utilisent des approches centrées sur l'art pour créer un rapport de confiance, promouvoir le partage d'un récit du vécu de la personne, et offrir l'opportunité d'observer la performance en activité. Ceci facilite une compréhension profonde de l'expérience de la personne, ainsi qu'une formulation de cas plus exacte des troubles mentaux d'adolescents et jeunes adultes. La Azima Battery est une évaluation expressive développer en ergothérapie spécifiquement pour activer la communication et faciliter le diagnostique d'individus avec des symptômes de psychose. La Azima Battery requiert la création de cinq objets en trois medium d'art (dessins, argile, peinture tactile). Ceux-ci sont offerts avec une installation et instructions d'ouverture de séance standardisée. L'évaluation procède ensuite par une entrevue phénoménologique exploratoire.

Objectif: Le but de ce projet était de valider et explorer le raisonnement clinique et l'utilité de la Azima Battery avec une clientèle suivie tôt dans le processus de la psychose, pour mieux détecter la schizophrénie naissante et comprendre le vécu de jeunes âgées de 15-35 ans en recherche d'aide. Les objectifs spécifiques était: (1) Compléter une revue critique de l'histoire du développement des évaluations projectives en ergothérapie, et clarifier les théories d'interprétation sur lesquelles elles sont basées, (2) Synthétiser les données scientifiques et les opinions experts pour leur utilisation clinique, (3) examiner la validité de la Azima Battery pour dépister la schizophrénie naissante avec une population admise aux services d'intervention précoce en psychose, et (4) explorer et illustrer une approche herméneutique phénoménologique dans l'analyse des séances d'évaluations avec la Azima Battery.

Méthodologie: Une étude a méthodes mixte, d'orientation herméneutique, a était conçu. Pour contextualisée les cadres d'interprétations sous-jacentes dans l'analyse de la Azima Battery, une revue critique de l'histoire et des données scientifiques a était entreprise pour les évaluations expressives projectives en ergothérapie. Ceci était accompagné par des entrevues avec neuf experts dans ce domaine clinique. En terme de validation, une collecte de donnée rétroactive a pris place dans les dossiers médicaux d'individus suivi entre 1997-2011 dans un programme d'intervention précoce pour la psychose, et qui ont aussi compléter une évaluation avec la Azima Battery avec une

ergothérapeute. (N=62). The validité de la formulation de cas par la Azima Battery a était calculer vis-à-vis le diagnostique a long-terme, et comparer a l'exactitude du premier diagnostique posé par le psychiatre répondant. En parallèle, des enregistrements audio-visuelles de séances cliniques d'évaluations avec la Azima Battery ont était complété avec neuf personnes suivi pour la psychose précoce. Ces enregistrements était analyser de deux façons: (1) les éléments de performance en activités projectives révéler par l'analyse phénoménologique descriptif (n=9) était quantifier et coder pour les créations de l'échantillon au complet (N=62). Des statistiques était appliquer pour explorer des motifs de performance qui sont distinctif pour un diagnostique de schizophrénie a long-terme. (2) Une analyse herméneutique phénoménologique a était utilisée pour interpréter et comprendre l'expérience des neuf participants, ainsi que la structure et le processus de la séance d'évaluation au complet. Une attention réflexive a était maintenue durant le projet de recherche a travers les méthodes multiples par le biais d'un journal de bord, et le dialogue avec une équipe de réflexion.

Résultats: La synthèse critique de l'historique des évaluations projectives en ergothérapie, et les perspectives des experts dans ce domaine de pratique a aider a proposer des lignes directrices pour l'utilisation clinique. Cette analyse a aussi révélé les tensions épistémologiques entre poser un diagnostique et une évaluation thérapeutique, nécessitant l'articulation d'un langage de raisonnement clinique qui peut marier ces deux objectifs cliniques. En terme de formulation de cas, cette étude démontre que la Azima Battery et plus exacte que le diagnostique initiale d'un psychiatre pour détecter la schizophrénie naissante (88.7% vs. 41.9%). Des motifs relier à la structure des créations sont révéler comme étant distinctif pour un diagnostique future de schizophrénie. En terme de l'analyse herméneutique, une compréhension profonde est offerte du vécu des participants. Ils ont une expérience d'une existence figée, un contacte vacillant avec le monde autour d'eux, et le sentiment d'avoir toujours était diffèrent et déconnecter, sur les marges. Le potentielle de la tache en argile d'être interprété comme un 'récit gestuelle' ou dramatique a révèle une métaphore dynamique de comment les participants (n=9) s'oriente envers, et s'engage avec, ce qui signifie le plus pour eux.

Implications: L'analyse herméneutique globale de ce processus de recherche relevé des mots de caution a propos de comment l'immigration ou l'abus sont conceptualiser dans le contexte de l'expérience de la psychose. Ceci ne sont pas des facteurs a risque dans le passée, mais plutôt des aspects de vécu qui continue a interagir dans la présentation et l'expérience de la personne. De plus, cette étude met en question l'épistémologie et le mode d'évaluation dans les services d'intervention précoce, ainsi que la conceptualisation de la psychose elle-même. Les implications pour le raisonnement clinique en ergothérapie sont discutées. L'utilité et la validité de la Azima Battery est démontré, et proposer comme une évaluation en ligne avec une politique de rétablissement pour les jeunes en recherche d'aide pour les troubles mentaux.

Statement of originality

This thesis presents data and ideas not published elsewhere except where specifically cited and referenced. The study findings and contributions described in Chapters Five, Six, Seven, Eight and Nine represent original material that contribute to the advancement of knowledge in the fields of occupational therapy and youth mental health. Specifically, this research project is the first to conduct a rigorous scoping review of the evidence of occupational therapy projective assessments, and to synthesize expert opinions into pilot clinical guidelines for use. This is the first time that scientific evidence is generated to support the predictive validity of an expressive occupational therapy evaluation in detecting a future diagnosis of schizophrenia, when used as part of the intake evaluation process within early psychosis services. The articulation and illustration of a hermeneutic phenomenological analysis as clinical reasoning for the interpretation of an expressive evaluation session is also a novel contribution. Finally, in terms of methodology, to my (doctoral candidate) awareness, it is the first time that mixed methods centered on phenomenological approaches are used in the validation of an expressive projective assessment for use with an early psychosis clientele.

This study was designed by myself, and my doctoral committee composed of Dr. Beverlea Tallant, Dr. Isabelle Gelinas, Dr. Barbara Mazer, and Dr. Steven Jordan. I was responsible for the recruitment of participants and data collection with both participants and other sources of data. Dr. Tallant participated in the data collection involving historical records. I conducted the descriptive phenomenological analyses and statistical calculations with the supervision and support of Dr. Tallant, Dr. Gelinas, Dr. Mazer and statistician Gevorg Chilingaryan. The hermeneutic phenomenological analyses were reviewed by Dr. Jordan and discussed with Dr. Tallant, Dr. Gelinas and Dr. Melissa Park. I wrote this dissertation, with contributions as described in the following section.

This study was approved by the Institutional Review Board of McGill University, as well as approved by the Research Ethics Office and Directeur Professionel de Services (DPS) of the McGill University Health Centre (MUHC) in an expedited review. The experts in this study were recruited by word of mouth from the occupational therapy community. The youth seeking help for mental health issues were recruited from McGill University's Mental Health Services for students (MHS) as well as the MUHC's Program for Early Psychosis Prevention (PEPP). The data in field notes and medical records were collected at the MHS, PEPP and the MUHC's Early Psychosis Intervention Centre (EPIC).

Contribution of Authors

I, Hiba Zafran, was the principal investigator for the series of studies presented in this dissertation. I was responsible for articulating and implementing the study design, collecting and analyzing the data, synthesizing the findings, and writing the manuscripts. This was done under the guidance of my thesis co-supervisors Dr. Beverlea Tallant and Dr. Isabelle Gelinas. I wrote the manuscripts in Chapters Five and Six, with edits and revisions suggested by my co-author, Dr. Tallant. Chapter Seven was co-authored with Dr. Mazer who served as a methods consultant, Dr. Tallant who supported the clinical and qualitative portions of the study, and Dr. Gelinas who provided revisions and feedback throughout. I also acknowledge the statistical support of Mr. Chilingaryan as co-author. The content in Chapter Eight was supported by the co-authors. Specifically, Dr. Tallant provided revisions to the manuscript, and Dr. Jordan participated in the data analysis process. All three authors were involved in the study design, and Dr. Gelinas supported the process of implementing the study. The doctoral committee critiqued and provided corrections for this dissertation based on their respective expertise and roles. Further acknowledgements for individuals who provided feedback are outlined in the respective sections of each manuscript.

Abbreviations

APA: American Psychiatric Association

APS: Attenuated psychotic syndrome

BLIPS: Brief, limited and intermittent psychotic symptoms

DSM: Diagnostic and Statistical Manual

EPIC: Early Psychosis Intervention Centre

FEP: First episode psychosis

JGH: Jewish General Hospital

MHS: McGill University's Mental Health Services for students

MUHC: McGill University Health Centre

MHCC: Mental Health Commission of Canada

MSSS: Ministère de la Santé et des Services sociaux

OT: Occupational therapy or occupational therapist

PASM: Plan d'Action en Santé Mentale

PEPP: Program for Early Psychosis Prevention

UHR: Ultra high risk

WHO: World Health Organization

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Preamble

"…story around the arrival of the topic" (Moules, Field, McCaffery, & Laing, 2014, p. 8)

> "The beliefs and behaviors of the researcher are part of the empirical evidence for (or against) the claims advanced in the results of the research. *This* evidence too must be open to critical scrutiny no less than what is traditionally defined as relevant evidence."
> (Harding, 1987, p. 9)

May 2007

I was a teenager when we first went to Beirut. Chaos, military, loud voices off the plane, pushing, bustling, undisguised hum of fear and expectancy: Crowds coming home. I'm shoulder-to-shoulder with my younger brother. Both of us eyes wide open. Moving sluggishly in the crowd.

The people look decorated. High frequency excitement. Post-war (not quite though). A despaired performance of belonging to counter-act the guilt of leaving and thriving, of having chosen not to stay.

We look to our parents for cues. Dad is joyous. We've never seen him like this before. He inhabits his skin, his space, his country. He has no fear. He is home. He is playful, birth language bubbling unrestrained out of him. I don't know this man but I already love him more than the Dad who works 12-hour shifts for us in a desert not our own.

Maman is tiny. She always has been. Blonde hair below my shoulder-level. She's ambivalent. Her eyes dart from finding the man she married years ago, to us, lost and unsure. Her banter is edged with…? She's jittery around all the different kinds of guards. She is trying to center the family and it's hard. The military is aggressively playful. Provocative. Wielding power. Some welcome the crowd home, making sure they understand who is in charge now. Others are unashamedly resentful. They scare me. I stay close to my brother.

I forget who picked us up out of the chaotic confusion of the airport's exit.

I can't look around, I'm so jolted by the lack of lanes, cars driving on pavements, up one-way streets, mopeds in between, cars honking incessantly, crude insults shattering my father's conversation, military checkpoints every few minutes, car swerving, dust, brother sunk in the middle seat. Maman looks out of the window. Her face is set in a mask of stone. Teeth clenched grimly, eyes melting. I look out, I turn by my window, to see what she sees.

Even now, the words don't come. I think lightening split me, I think I dissociated. I can't find that feeling but I remember the images. Everything was broken and crumbling. Everything. Bullet-ridden walls. Fallen-over statues, leaking fountains, shattered pavements, torn walls. The sky was a blue-blue, soft clouds tearing at the opacity of it. *This is where we are from?*

It's hot. My panic begins to well and I start to feel nauseous as the car continues its unrhythmic motion. My pants stick to my legs. My breathing gets shallower. I keep looking, my hands restless in my lap.

The walls were all a sun-kissed yellow, mustard yellow, aged-white yellow; pockmarked with bullets, jagged black holes, ripped façades, no frontage the insides exposed unwillingly; walls with forged metal balconies clinging to the contours waiting to jump away.

I feel the world slide inside me

There is no ground. It is literally broken

There will never be a ground again

I forget to breathe. I feel wet all over

There is no sound in this memory

People are everywhere. Rummaging, talking, pushing. Carts in the street. Mattresses in building holes. Muslim coverings and not. Beautiful plants tended in the ruins. Laundry undulating in the dust. We arrive.

We arrive to my dad's cousin's house. Small and clean. We eat on a roof top garden made of salvaged bricks, barrels, buckets and tarp. We sit on crates and stools and a homemade hammock. I am only conscious of my father's joy and emotion. No one else. And my anguish, rising, at the loss he has chosen in order to keep us safe.

We are driven to my grandmother's house, where my father was born. I remember fruits, ripe and fresh, sold on the pavement. It is a torn house, bullet paths and ricochets on the inner walls but the outer walls are standing. I *know* this place. He's never talked about it before but I remember the ladder, and two bedrooms for parents and four kids. I even know where to point to where my father slept. How do I know this? The world is shattering, like sliding glass, it feels as if it's cutting me.

I find out many years later that it wasn't *my* first time; that Dad had taken me there when I was three during a cease-fire. Just the two of us. My parents look for the photographs that were hidden before leaving. They're all gone. I've only ever seen a handful of black and white photographs of my parents' childhood.

Sound comes back

I don't remember getting on the plane to Beirut, or the days before that. I don't remember how we got to the hotel. But I remember, I *feel*, the crumbling as we enter our sane-sanitized hotel rooms overlooking living destruction and I remember the sobbing starting, but not ending.

Maman baleful at my Dad

My Dad stoic yet lost

My brother small, more scared of my crying than of Beirut.

Later that night (or another night much later?) overhearing my parents talking. Maman is worried about me. Very worried. She talks about seeing a psychiatrist or a therapist. My Dad refuses. I sense through the walls the feeling of *"This is her story, her people"*.

I was mute for three days

I remember the silence and the wet

Eyes open, tired, sleepless

The insomnia and waves of mood were there before, and stayed for a long time after.

Much later, back in the country we were living in, I am taken to see a specialist of some kind, to whom I tell very little. I don't have the words. He suggests 'activity', that I find something I can get wrapped up into. I ask for paints. Night arrives, and sleep doesn't. This time, I get up and unpack my new paints. And begin to paint on my bedroom wall. I paint for hours through the night. An underwater scene replete with orca, starfish, dolphins, seahorses, coral reefs. A calm descends with each stroke as I cover the wall I can see from my bed with a softer world.

In exploring what it is to conduct research as a participant-observer, Behar says, "vulnerability doesn't mean that anything personal goes. … a personal voice, if creatively used, can lead the reader, not into miniature bubbles of navel-gazing, but into the enormous sea of serious social issues" (1996, p. 14). I have learnt that it takes practice to shift the focus from manifest content to the latent meaning of the experiential unfolding, to what lies beneath the actions and behaviors, that silent or inarticulate immigrant teenagers carry worlds and worlds within them well beyond categories or reductive explanations. I did graduate in Marine Biology, exploring an underwater world with no walls to fragment. Yet, I somehow arrived here, in a profession that believes in the value of 'meaningful doing', offering clay and paint to immigrant youth as the ground of their self and world slips and tears.

"At the core we are all the same, there is no us and them"
(Mental Health Commission of Canada, 2009, p. 9)

Chapter One: On Entering

> "To give a thing a name, a label, a handle; to rescue it from anonymity, to pluck it out of the Place of Nameless, in short, to identify it – well, that's a way of bringing the said thing into being."
> (Rushdie, 1990, p. 63)

1.1 Psykhosis

The idea of 'psychosis' engenders all forms of evocative images and reactions in everyday culture that speak of a state of fragmentation and disconnect from self and others. The term 'psychosis' derives from the Greek and refers to an abnormal derangement of the mind. Yet, this is an inversion or play on the original meaning of the term *psykhosis* pertaining to that which animates, the soul or principle of life (Harper, 2001-2014). Thus, the historical cluster of meanings that surround the term and diagnosis of psychosis are grammatically and figuratively located in our horizons of personhood, and what vitally moves us.

The current medical-diagnostic criteria for being in a psychotic state involve the loss of contact with reality, either through distorted sensory experiences such as hallucinations, clusters of delusional beliefs and behaviors not grounded in a shared cultural world, or through the loss of this vital animation, labeled negative symptoms (American Psychiatric Association, 2013). Negative because aspects such as motivation or pleasure are missing from the individual's experience. There are many reasons why someone might develop a psychosis. They include the onset of a major psychiatric disorder such as schizophrenia or bipolar illnesses, to having a fragile personality structure such as borderline personality disorder, a drug-induced state of psychosis, a neurological condition such as temporal lobe epilepsy, and/or as a consequence of extreme traumatic experiences. The potential triggers for a psychotic episode and eventual diagnosis are only clarified over time (Rahm & Cullberg, 2007). Regardless of the potential causes, in seeking to create and implement recovery-oriented mental health policies, the World Health Organization conceptualizes psychosis as an existential "crisis of being that value and meaning can be derived from" (O'Hagan, 2009; cited in World Health Organisation, 2010, p. 2).

1.2. A decade of clinical care

Early intervention in psychosis aims to detect and intervene to diminish the length and effects of psychosis, in particular for those with a potential of a first episode of schizophrenia. Since the 1980's the notion of schizophrenia as a precocious deteriorating disease of the brain (Kraepelin, 1962) was replaced by the medical concept of an episodic chronic illness which can be managed and treated if caught early (Yung et al., 1996), similar to cancer or cardiac conditions. Yet the recent global movement to rethink and treat individuals with psychosis and schizophrenia continues to challenge clinician's understandings of what psychosis actually is, how psychosis is lived, and, therefore, what is best in the provision of everyday clinical care for youth (Tranulis, Zafran, Whitley, & Park, 2011).

As an occupational therapist working for 10 years in the first Montreal center for early intervention in psychosis trying to therapeutically engage with help-seeking youth, I have certainly encountered what

Davey describes as "individual experiences of finitude in which the real limits of human understanding are encountered" (2006, p. 7). By this I mean that the theories and approaches which I had learnt and which my colleagues in psychiatry had socialized me into were inadequate to describe what I was experiencing in both my successful and failed occupational therapy informed attempts. There was something happening in the space *between* my clients, myself, and the therapeutic evaluative activities in which we engaged that remained unaccounted for, invisible, and for which I initially had no words. More importantly, the adolescents and young adults I was working with had few words to share what was happening to them in their initial contact with the early intervention services.

Our ways of knowing our patients are predicated upon the ways in which we 'allow' them to tell of themselves, and the ways and lenses with which we listen within health care encounters. The onset of mental illness can engender identity and communication difficulties that make it difficult to connect and understand one another across experiential worlds (Kirmayer, 2007). Yet, this connection is necessary in order to co-create a shared understanding and to offer meaningful and successful health care encounters and therapies. It is sobering to note that the etymological root of the term 'encounter' is that of a confrontation, a meeting of adversaries (Harper, 2001-2014). This is pragmatically addressed by early intervention guidelines stating that the choice of evaluation tools and approaches needs to meet the objectives of facilitating understanding of the client within their own language and culture. Further, to foster therapist-client connection and collaboration, and to focus on case formulation that leads to the development of a strengths-based and meaning-oriented intervention plan (Ehmann, Hanson, Yager, Dalzell, & Gilbert, 2010). This doctoral thesis examines an occupational therapy assessment tool – the Azima Battery- as an approach that fulfills these guidelines when used as an initial evaluation with youth seeking help within early psychosis intervention services.

1.3. Naming the process of entering: In between me, you, and It

Health care encounters occur both between people and concrete activities – be they evaluative activities or intervention intended ones. While this conceptualization is at the core of occupational therapy, it is much less visible in psychiatry, a primarily verbal field. In other domains of medicine the activity is an obvious part of the connecting or alienating process (invasive testing, physical treatments). Approaches in psychiatry are primarily conceptualized as a relationship between two individuals, with some interest in problematizing the potential "it" hanging between the two of them. The ubiquitous term 'it' is "used to represent an inanimate thing… in statements expressing an action, condition, fact, circumstance, or situation *without reference to an agent*" (Merriam-Webster, 1997, pp. 365, emphasis added). Yet, during the process of evaluating for mental health case formulation, 'it' is the clinician's assumptions about the nature of psychosis (Larsen, 2007a) and the intentions of clinicians to act as moral agents for care (Mattingly, 1998b). "It" could also be the experiences of patients negotiating or resisting their uptake of personhood in psychiatry (Barrett, 1996; Williams, 2008). In addition, "it" could be the cultural differences between clients and health care

providers (Mattingly, 2008). Finally, hanging between a client and therapist is the process of mental illness itself that can obscure communication and relating. In occupational therapy 'it' also refers to a therapeutic task or activity.

Of central significance is the close attention to these assumptions, intentions and interpretive lenses that 'hang' in between therapists and clients, as mediated through the construction of language, and the content and structuring of interviewing processes in health care encounters. "The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity" (Shephard, Boardman, & Slade, 2008, p. 2). The ways of knowing and seeing by which clinicians predicate the structure of what they ask and listen for profoundly molds clinical impressions, case formulations, and clinical judgments. Ways of knowing in occupational therapy are occupationally based, whereby an activity is purposely offered to facilitate the showing or expressing of one's experience or ability, and by interpreting the individual's mode of being through observing the 'doing' of an activity.

The critical examination of a projective (using expressive media) evaluation tool from a multiplicity of epistemologies, in comparison to traditional psychiatric diagnostic interviewing, illustrates and raises questions about the impact of the 'how' of evaluation on the validity of case formulations. This has implications for clinical diagnosis and decision-making. How does questioning and shifting our framing of the evaluative 'it' change our ideas of what is 'wrong' with someone? What is the clinical validity and utility of such an approach?

This doctoral thesis studies the **naturalistic clinical validity and interpretive reasoning of an occupational therapy projective evaluation tool (the Azima Battery) with help-seeking youth early in the process of experiencing psychosis**.

1.4. Entering this thesis

This dissertation includes both chapters and manuscripts, and is organized according to the structure and requirements of a manuscript-based thesis, thus there may be some overlap and repetitions, with introductory content and discussions throughout. It includes a literature review of the primary domains of concern, details of the development of a mixed methods study design, four empirical manuscripts, linking statements, and a final discussion as an overarching meta-synthesis, as well as appendices. Due to the nature of the manuscript-based design as well as the mixed methods used, conclusions, implications, and recommendations are made throughout the thesis. The chapters are organized to situate the reader in relation to the inquiry, provide a justificatory rhetoric for the mixed methodology, and present the research findings in an epistemologically coherent narrative.

In the following chapter (Chapter Two), the literature is reviewed in relation to the following: the shifting values and foci of new mental health policy currently being implemented in Quebec and across Canada; the scientific and clinical evidence for early detection in psychosis; the epistemological and policy-

driven gaps between empirical findings and clinical evaluation approaches; and the contribution of occupational therapy clinical reasoning and expressive projective assessments. The rationale for this study is built in more detail through this process, culminating with pilot data, and a brief Chapter Three outlining the objectives of this research project. The intertwined phenomena investigated here are (1) the structure (or form) of the psychotic experience as revealed through activity performance in a given set of projective media, and (2) the projective evaluation session as a whole clinical phenomenon within which the meanings and experience of psychosis are elicited, explored and understood, with help-seeking youth.

Chapter Four provides an overview of the rationale and operationalization of a hermeneutic mixed methods study design. Data collection involved the use of multiple strategies in relation to participants, context, phenomena, and the researcher's experience. Data was composed of historical publications, interviewing nine experts in this domain of practice, participant-observation in conducting nine clinical projective evaluation sessions, and reviews of the medical records (texts) of a total of 62 young adults followed in an early psychosis intervention program. In addition, field notes and reflective journals were kept prior to, and throughout the research and dissertation process. Data analysis was primarily qualitative with an embedded quantitative component. For each aspect of the project, the most fitting qualitative approach was used (from descriptive to interpretive phenomenology, and hermeneutics). "Integrative efficacy" is the combination of all the results into a consistent, theoretically coherent meta-inference that is supported by expert consensus and the literature to date (Teddlie & Tashakkori, 2009, p. 305). This was an iterative hermeneutic process "whereby patterns in complex wholes are illuminated" by understanding the meaning of the different parts of the study in relation to the whole, to each other, to history and context, and back again (Alvesson & Sköldberg, 2009, p. 91). This over-arching reflexive process of interpretation also took into account the situated nature of the researcher and the research project, and the epistemological "bumping" (Zafran & Park, Submitted) and mixing that occurred within the project across methods, and in dialogue with the supervisory committee members.

Chapters Five and Six are a two-part article entitled "It would be a shame to lose them. A critical historical, scoping and expert review on the use of projective assessments in occupational therapy, Part I &II" published in the journal *Occupational Therapy in Mental Health*. These empirical manuscripts are composed of four sections and provide a detailed history of the development of occupational therapy expressive projective assessments in North America. The results of a scoping review of the current evidence-base for the clinical use of these assessments are outlined in Part I. This is followed by a narrative analysis of the practice-based opinions of nine occupational therapy experts in the domain of projective assessments in Part II. Through this comprehensive process, the historicity and clinical utility of projective assessments are traced, and conceptual and methodological issues are articulated, in order to suggest clinical guidelines and future research avenues.

Chapter Seven is a manuscript entitled "Detecting incipient schizophrenia: Validation of the Azima Battery in First Episode Psychosis" prepared for submission to the *Canadian Journal of Occupational Therapy*.

This empirical manuscript outlines the embedded sequential-exploratory subsection of the research study whereby descriptive phenomenological observations of activity performance occurring during the Azima Battery session were "quantitized" (Sandelowski, Voils, & Knafl, 2009, p. 208) into nominal variables. These variables were statistically analyzed for criterion validity of the Azima Battery case formulation at intake in comparison to standard psychiatric diagnostic interviewing, and longitudinal diagnostic outcomes, in a sample of 62 youth with early psychosis. The results outline the diagnostic accuracy of the clinical reasoning and impression generated through the use of the Azima Battery, along with a descriptive profile of projective activity performance elements distinctive of a later diagnosis of schizophrenia.

Chapter Eight is a manuscript entitled "The phenomenology of early psychosis elicited in an occupational therapy expressive evaluation" prepared for submission to the journal of *Transcultural Psychiatry*. This manuscript explores and illustrates an in-depth hermeneutic phenomenological analysis of the structure and meaning of the psychotic experience for nine participants, as revealed during the clinical Azima Battery evaluation session. The findings describe the tenuous intentional arc between the participants and the world around them, and the experience of time being frozen. The participants' narratives of having always experienced being different are explored. The observations of activity performance that support these interpretations are described, particularly the potential for the interpretive and expressive use of clay as a visually dynamic metaphor of these participants' modes of being-through-doing.

The thesis ends in a discussion chapter (Chapter Nine) that provides a hermeneutic integrative synthesis of the project as a whole. In this final chapter epistemologies of evaluations in mental health are revisited in light of the mixed methods findings, with implications for the conceptualization of the ontology of psychosis. The speculative nature of activity performance and interpretive possibilities are discussed; and the clinical implications of using the Azima Battery from a hermeneutic-interpretive framework are summarized. The contributions to early intervention in psychosis, occupational therapy, and methodology are reviewed. Finally, limitations and future research queries are outlined.

1.5. A note on the philosophical orientation and tone of this thesis

The judicious use of critically multiple epistemologies (Miller & Crabtree, 2005) that are each judged by their own criteria for merit and integrated together rather than conducted side by side (Teddlie & Tashakkori, 2009) rendered the writing of this thesis a challenge. Thus, the rhetorical tone of the chapters and manuscripts shifts dependent on which part of the study is being presented, and to which intended audience. The reflexive attunement to these shifts in tone and researcher states of being has been part of the research process itself (Jackson, 2010).

Although this project is a mixed methods health measurement study for the validation of a specific arts-based occupational therapy evaluation tool (the Azima Battery), the underlying philosophical explorations, as well as empirical findings, refer to a broader set of moral and clinical implications. Both health care professionals and patients "continue to struggle to present their experience in language that calls

for close listening and imaginative engagement" (Kirmayer, 2008b, p. 457). In many ways, this research undertaking has involved the slippery ground of turning my own lived experience, as well as those of the participants, into legitimate translatable knowledge. In choosing to scaffold a research process that makes visible and examines an *ontology of the in-between* (Davey, 2006; Jackson, 1996) I have had to attend carefully to the ways in which both the observed, the invisible, and the experienced-as-data are 'taken' rather than given (Sandelowski et al., 2009), and rendered into both words and numbers. At times the use of poetic or literary prose, or metaphorical language, is necessary to open avenues of meaning for both the researcher and the reader (Davey, 2006; Kinsella, 2006b; Kirmayer, 2007; Leavy, 2009). In particular, over the past 25 years, the words of Salman Rushdie have guided my articulation and understanding of immigration, identity and psychosis generated from within and from without. I share these throughout the thesis.

I would like to leave this introduction with one of the metaphors which has guided my experience of conducting and writing a mixed methods study (Bazeley & Kemp, 2011). Similar to turning to research at one point in my clinical career for a shift of perspective and knowing, at one point in my training as a classical pianist I turned to ragtime music. Ragtime is a form of dance music predicated on a 'ragged' rhythm whereby the left hand plays bass notes accompanied by the right hand playing a syncopated melody. This results in what has been termed a melodic denial, which is "the defining characteristic of ragtime music…a specific type of syncopation in which melodic accents occur *between* metrical beats. This results in a melody that seems to be avoiding some metrical beats of the accompaniment" (Wikipedia, 2014, emphasis added). The resulting effect is that the beat is accentuated, and the listener moves to the music.

In juggling between qualitative and quantitative methods (Bazeley, 2009), between phenomenological and medical discourse (Hasselkus, 2011), and between my immigrant, clinician and researcher selves (Lawlor, 2003) the tune has certainly been syncopated. As in my early experiences of playing ragtime, the melody was unclear and the learning frustrating. It may have been easier to default back to a classical mode. Yet, it is in the syncopated rhythm that one begins to move, to hear something different, between and within the epistemological tensions and contradictions of mixed methodology practices and findings.

Chapter Two: Reviewing the Interrelated Literature, Constructing a Rationale

In this chapter the relevant legal and health care history and context of early psychosis intervention is outlined, followed by the evidence to date for detecting youth at risk of developing schizophrenia. Gaps and challenges in current knowledge, epistemologies of diagnostic practice, and ethics are described, followed by an argument for studying the clinical reasoning and clinical utility of an occupational therapy projective assessment with youth accessing early psychosis intervention services.

2.1. The shifting landscape of mental health in Quebec

There are vast changes currently occurring in mental health practice across Canada and the world (World Health Organization, 2012), calling for a mental health practice that is recovery-oriented, accessible, and empowering (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). In this global and local context, privilege is given to approaches that valorize the individual's experience, culture, and voice. It further places primacy on the quality of therapeutic relationships, the nature of engagement, and non-technological approaches to foster these (Bracken et al., 2012). In Quebec, these values are holistic and focus on respecting the individual's way of being and their perspective, their way of engaging with the world around them, and their human rights (Ministère de la Santé et des Services Sociaux, 1989). The Mental Health Commission of Canada has also outlined a strategy for mental health which involves shifting from a dominant biomedical approach to one that acknowledges and dispels stigma to foster recovery, identity and personal meaning (Kirby & Keon, 2006). This includes providing the best possible evidence in meeting the service needs of a diverse population with an accent on health promotion (Mental Health Commission of Canada, 2012). In Quebec, as in many other places, one focus has been placed on preventing and detecting mental illness in youth.

The Plan d'Action en Santé Mentale (PASM) in Quebec names the complexity of diagnosing adolescents and young adults due to ongoing developmental growth and change, therefore this provincial policy highlights the necessity of prioritizing interdisciplinary evaluation approaches (Ministère de la Santé et des Services Sociaux, 2005). This is in tandem with new mental health policies and ensuing legislature, particularly Bill 21 in Quebec, whereby all mental health professionals are being called to aid in the screening for suicide and diagnosis of mental health issues (Office of Professional Orders in Quebec, 2013). Thus, all disciplines are called upon to appraise their evaluation tools in light of the evidence-base for these practice philosophies and values (Kirby & Keon, 2006; Petrova, Dale, & Fulford, 2006) when providing mental health services for youth.

2.2. Early intervention in psychosis: Recovery in action

In Canada, psychotic-spectrum disorders account for up to 67% of psychiatric hospitalizations, with an average age of onset between 15-25 years of age (Health Canada, 2002). Psychotic-spectrum disorders are

estimated to be the third most disabling condition worldwide in youth (World Health Organisation, 2001). The experience of psychosis involves the loss of contact with the reality of one's self, others, and the shared world around us. It is a symptom common to persons with various major mental disorders, and is a core diagnostic feature of persons with schizophrenia-spectrum disorders (American Psychiatric Association, 2013).

The focus on health promotion and recovery in youth mental health is exemplified by the global early intervention for psychosis movement (McGorry, 1992). Clinical efforts to identify youth at risk for psychosis have been a mainstay of psychiatry for the past century, with pioneers such as Sullivan (1927) and Arieti (1958/1974) publishing case descriptions of youth in the process of developing psychosis. Beginning in Australia 35 years ago, the mission of formalized early psychosis intervention is to detect psychosis early on, in order to prevent and attenuate the devastating effects of psychotic-spectrum disorders in youth, particularly schizophrenia. This is known as 'secondary prevention' whereby medical and psychosocial sequelae of psychotic illnesses, such as unemployment and loss of social networks, are targeted and minimized to improve recovery and long-term outcomes (Jackson & Birchwood, 1996). Currently this is done with the intention of respecting recovery principles through community outreach, family-centered care, and the provision of services in naturalized environments (Bertolote & McGorry, 2005). This integrative orientation to intervention is not necessarily incorporated into diagnostic practices.

2.2.1 Detecting "Ultra high risk" youth

In the 1980's, signs for incipient schizophrenia were developed in Australia based on the third Diagnostic and Statistical Manual (DSM-III) (American Psychiatric Association, 1984). This version of the DSM shifted from a psychodynamic perspective of mental illness to focus on developing 'atheoretical' diagnostic criteria with psychometric validity. Although intended for use as a research manual, the DSM-III and subsequent versions are the standard clinical approach to diagnosis in the United Kingdom, Australia and North America. Early versions of checklists of presumed 'at risk' signs were initially deduced from the full-blown symptoms of schizophrenia, or in situations of relapse in already diagnosed youth, as described in the DSM-III. Thus, examples of symptoms of the schizophrenia prodrome in adolescents include mild auditory disturbances such as hearing white noise or occasional, indiscernible whispers; magical (or superstitious) thinking well past the normal developmental age of 10-11 years; increasing social anxiety due to suspiciousness about the intentions of friends and family; cognitive disturbances such as reduced concentration; and mood changes such as decreased motivation and increased sadness, anxiety or irritability (Yung & McGorry, 1996). Unfortunately, on their own, these early checklists did not yield satisfactory detection; rather, when used in a community survey of Australian high school students to determine the prevalence of these symptoms in the general population of adolescents, they found that half the sample (49.2%, N=2525) had two or more symptoms and hence met the criteria for the revised DSM-III prodromal schizophrenia (McGorry et al., 1995). The authors concluded that the DSM-III-R criteria were not specific to

early schizophrenia in a general community sample. In addition, in a clinical sample of individuals with both affective and non-affective psychosis, these criteria did not demonstrate discriminatory validity (Jackson, McGorry, & Dudgeon, 1995). This led to the search for more accurate ways to detect the early stages of schizophrenia.

Further research and conceptual development led to the notion of 'ultra high risk' (UHR) youth, with outreach and evaluation strategies that could 'close-in' more accurately on distressed youth actually seeking help, and at potential risk of developing a full-blown psychotic disorder (McGorry, Yung, & Phillips, 2003). At present, this close-in model relies on a biomedical orientation to mental illness and includes some of the original 'Melbourne criteria' (Parker & Lewis, 2006) described above. The UHR criteria require the presence of behavioral and genetic risk factors such as having first or second degree relatives with a psychotic-spectrum diagnosis, in conjunction with a decline in psychosocial functioning, or the presence of brief, limited or intermittent actual psychotic symptoms known as BLIPS (Nelson, Yuen, & Yung, 2011). Following decades of research, the original Melbourne criteria have been refined into scales that include identified risk factors, such as the Comprehensive Assessment of At-Risk Mental States (Yung et al., 2005), and Psychosis-Proneness Scales (Horan, Reise, Subotnik, Ventura, & Nuechterlein, 2008). This 'closing-in' approach to detection in research-oriented community clinics predicts 35-54% (McGorry et al., 2003) – or more conservatively, 15-40% (Parker & Lewis, 2006) of confirmed transition to psychotic-spectrum disorders within a year of identification.

There are ethical and scientific dilemmas with these statistics and the misidentification of youth at risk of psychosis. Psychosocial interventions during stressful times in adolescent development and the transition into young adulthood have demonstrated positive outcomes for youth deemed at risk of developing psychosis (Addington, Francey, & Morrison, 2006). However, the label of being 'at-risk' has profound implications for identity development during adolescence, particularly in terms of self-stigma about losing one's mind (Yang, Wonpat-Borja, Opler, & Corcoran, 2010). Further, there are iatrogenic issues in using psychiatric medications in a preventive manner, such as cardio-metabolic risks and weight gain side effects of antipsychotic medications (Correll et al., 2009). There are also questions about the clinical utility and naturalistic validity of these types of research-driven objective scales (Yung et al., 2012). In spite of decades of research, these ethical issues need to be prioritized over psychometric considerations in assessment approaches to detection. In fact, an attenuated psychosis syndrome (APS) was proposed – and eventually rejected - as a formal medical category for inclusion in the 2013 fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (Maxmen, 2012; Nelson & Yung, 2011).

Historically, approaches to understanding the onset of schizophrenia were based on the use of phenomenological interviews that focused on the individual's way of being in, and relating to, the world (Chapman, 1966; Chapman & Chapman, 1987). Contemporary phenomenological studies have demonstrated that subjective, experientially-based signs, such as the self-reported loss of the sense of agency over one's thoughts, or the feeling that the environment is not quite real; have a much higher predictive value of up to

70% over one to 15 years later (Klosterkötter, Hellmich, Steinmeyer, & Schultze-Lutter, 2001; Nelson, Yung, Bechdolf, & McGorry, 2008). Critics have stated that "[c]ontemporary psychopathology, as a result of a behaviorally dominated epistemological stance, downplays anomalies of the patient's subjectivity … [where] experiential anomalies appear to be relevant for early differential diagnosis" (Parnas, Handest, Sæbye, & Jansson, 2003, p. 126). Therefore, in addition to observable UHR signs that are biomedically conceptualized and psychosocial problems that are categorically quantified, there is a need to continue exploring and describing these subjective phenomena from a first-person perspective and interpretively understanding the actual experiences of youth with incipient schizophrenia. It would also be fruitful to qualitatively describe the patterns of decline and activity limitations of help-seeking youth beyond categories of functionality (e.g. is or is not employed), as this could lead to the improved identification of vulnerable persons (Chapman, 1966; Møller, 2001; Woodside, Krupa, & Pocock, 2007). This qualitative first-person approach is also in line with current mental health policies and values, as described above.

2.2.2 Subjectivity and psychosis

To date, research-based conceptualizations of the subjective experience of psychosis for diagnosis have been framed using phenomenological (descriptive, interpretive, and hermeneutic) approaches to understanding (Rulf, 2003). These differing orientations to phenomenology emerged from the philosophers Husserl, Heidegger, Gadamer and Merleau-Ponty (Nelson et al., 2008), and were first extended into phenomenological psychopathology by European psychiatrists such as Minkowski, Jaspers and Binswanger (Monti, 2005).

These phenomenological terms refer to three ways of approaching and understanding the psychotic experience. Descriptive phenomenology in the study of psychopathology focuses on the form or structure of an experience and how it is presented (Parnas et al., 2005), for example the structure and process of engaging in an activity in a certain way. Interpretive phenomenology aims to elucidate the meaning of lived experience (Benner, 1994), for example the meaning that individuals try to create out of their experience of impending psychosis within their life worlds, through first-person narratives (Larsen, 2004; Minkowski, 1948; Stanghellini & Ballerini, 2007). Finally, hermeneutics in the diagnostic process takes interpretation further by implicating the skills of the therapist-interviewer in co-creating and interpreting a narrative account about the 'whole' (or gestalt) of an individual's experience (Stanghellini, 2010). That is, a hermeneutic approach implies the deep engagement of the interviewer with the interviewee, and necessitates the reflexive, or active interrogation (Phelan, 2011), and articulation of the interviewer's 'preunderstanding' (Davey, 2006) and assumptions. Thus, interpreting an individual's experience occurs within an acknowledged intersubjective relational connecting that is reflective (self-aware), adaptable, and tailored to the individual (Stanghellini, 2007).

Based on phenomenological research of psychopathology that is historically and geographically centered in Northern Europe, it is postulated that the core neurobiological disturbance in psychosis is

phenomenologically lived as a disturbance of the experience of 'self' (Parnas, 2000). These experiences have been described using psychiatric terms such as depersonalization and derealization, perplexity and confusion, motor or verbal disturbances, deautomatization of motor actions, thought pressure or blocking, thoughts interfering with the normal stream of consciousness, and loss of the experience of bodily demarcation (Hunt, 2007; Nelson et al., 2008). At the heart of these labels is a disturbance of ipseity. 'Ipseity' is a phenomenological concept broached by many philosophers, which can be distilled into the idea of the embodied and pre-reflective knowing of the 'mineness' or 'givenness' of our experiences (Zahavi, 2005, pp. 113-116). That is, when we have a thought such as 'I'm hungry' or engage in actions such as typing on a keyboard, we do not have to question 'who is hungry' or 'whose fingers are moving'. We just know and take for granted that this is *my* hunger, *my* fingers. This automatic knowing is lost in psychosis. To summarize the complex language of phenomenological psychopathology, it is the loss of ipseity, or the inability to unquestioningly experience self vs. nonself, that is named 'psychosis'.

These changes in body and consciousness lead to attempts for a meaningful existential reorientation, through the creation of a narrative to account for the shift in subjectivity. "This style of awareness objectifies aspects of oneself that are normally tacit, thereby forcing them to be experienced as if they were external objects" (Nelson et al., 2008, p. 387). The concreteness of thoughts that are meant to remain at the level of tacit awareness engenders feelings of foreboding, and eventually an outright sense of danger, persecution and despair. The world becomes chaotic as the person loses the ability to 'read' and connect to ordinary everyday life (Corin & Lauzon, 1994). The temporal quality of existence becomes frozen, without a momentum towards a future, as existential possibilities have been foreclosed by the sense of danger (Binswanger, 1987; Minkowski, 1948; Mundt, 2005). Bodily experiences change, with a sense of inner emptiness and strangeness (Hunt, 2007). The person having these experiences tries to create a culturally informed narrative to make sense of what is happening, and to manage the ever increasing anxiety (Colbert, Peters, & Garety, 2006), such as a belief perhaps that a government agency has placed a microchip in their head to control their movements. Although loss of connection to the world, meaning, and agency are often described as the psychosocial *consequences* of many acute and chronic illnesses, life losses or accidents; in the living of psychosis these phenomena are understood as the core, the '*trouble générateur*' (Minkowski, 1927), from which checklist symptoms such as hallucinations and delusions arise as epiphenomena.

2.3. Linking policy and science to evaluation: The gap

Many of these phenomenological explorations into the lived experience of psychosis were initially conducted with adults with long-time recurrent psychosis, and elicited verbally through the use of interviews. For the European studies qualitatively exploring the onset of early psychosis cited herein, the average ages range from 25-35 years. The average age of onset in Canada is 15-25 years (Health Canada, 2002), a full decade less than in many of these reported studies. This is partly due to the fact that psychosis impairs processes of thinking and communication (American Psychiatric Association, 2000), thus making diagnostic

interviews a challenge. Youth, experiencing as yet unnamed shifts in subjectivity, have difficulty articulating and sharing these inner changes which occur at the same time as developmental processes of identity formation during late adolescence and early adulthood (Harrop & Trower, 2003). This is an issue noted early on in descriptive phenomenological studies by Chapman: "…it was apparent that although the disease was not advanced, the patients nevertheless had difficulty in communicating their subjective experiences and that interviewing by question and answer was likely to provide limited information" (1966, p. 278).

In addition to the challenges of interviewing help-seeking youth, recovery oriented early intervention guidelines state that "assessments must take into account the client's culture and language and how these affect ability to access and benefit from services" (Ehmann et al., 2010, p. 38). In spite of policy, North American psychiatry remains biologically oriented, without a mainstreaming of phenomenological approaches to clinical evaluations (e.g. Parnas et al., 2005). Although locally (Quebec) there is Bill 21 which states that all mental health professionals are to aid in the diagnosis of mental health issues (Office of Professional Orders in Quebec, 2013), a gap remains between the pragmatic and medical epistemological orientations of clinical practices, and the recovery values and experience-first epistemologies of phenomenological research outcomes. Each discipline will need to address this issue in evaluating and conceptualizing mental health issues amongst youth.

2.4. The contribution of occupational therapy

Occupational therapy's focus is on evaluating and intervening for meaningful engagement in the activities of everyday life. The heart of occupational therapy lies in its psychosocial core (Fidler, 1995; Ikiugu, 2010), and its ongoing endeavor to understand personhood from the relationally mediated experience of a lived body engaged in doing (Kielhofner, 2008; Phelan & Kinsella, 2009). From its roots in the moral treatment of mental health (Meyer, 1922), occupational therapy has always been oriented towards treating individuals with mental illness with dignity. Respecting cultural diversity (Gerlach, 2012), and critically appraising what is meant by 'client-centered practice'(Corring & Cook, 1999; Restall & Ripat, 2008), are considered essential by occupational therapists in order to promote the citizenship of psychiatrically diagnosed individuals. Occupational therapy is a profession that currently finds its values well aligned with those of mental health policy.

Occupational therapy has developed theories and approaches in order to address constructs such as connectedness, meaning and agency (Hasselkus, 2011), which are all of import in the phenomenological understanding of the experience of psychosis. The advantage of occupational therapy evaluations is the combination of both the narratives of experiences along with the observation of performance in activities that can foster expression. In this way, the individual shows and reveals that which they may not be able to tell or say.

2.4.1. Expressive projective assessments

Projective techniques "evoke from the subject what is in various ways expressive of his private world" (Frank, 1948, p. 47). Specifically, expressive projective techniques use artistic media to promote dialogue, to observe patterns of performance, and to achieve a therapeutic model of assessment. The expressive projective process allows a window into a youth's inner state of being, when other more direct, verbal methods fail to detect a vulnerability to psychosis. Art-based, visual inquiry provides an "embodied, multi-vocal, and non-linear representational potential" (Butler-Kisber, 2008, p. 266) which can help both bypass and expose the impairments in perception, thinking and feeling that occur in psychotic disintegration. The individual who engages in artistic doing reveals aspects of himself or herself beyond linear verbal knowing, "from the intersection of subjectivity with medium" (Green, 2001, p. 4). A comprehensive scientific review of the research reveals that broadly speaking, projective assessments are well-suited to detecting psychosis (Lilienfeld, Wood, & Garb, 2000).

Research also highlights the effect of the evaluator's presence and skill in eliciting projective associations (MacFarlane & Tuddenham, 1951; Tallant, 1966) with "intuitive" evaluators facilitating the establishment of therapeutic rapport and engagement as well as more accurate interpretations (Schmidt & McGowan, 1959). The intersubjective creation process leads to richer, person-centered information gathering. Epistemologically, this contrasts with, and complements, medically centered diagnostic interviewing. The projective productions and associations of help-seeking youth offer a qualitative representation of a subjectivity tinged, or taken over, by psychosis. The particular expressive projective assessment used in this research project is the Azima Battery (Cramer-Azima, 1982).

2.4.2 The Azima Battery in occupational therapy

The Azima Battery is the first formally published assessment in Canadian occupational therapy. It was developed in the late 1950's by the psychiatrist Dr. Hassan Azima and his wife, psychologist Dr. Fern Cramer-Azima, at the Allan Memorial Institute in Montreal. They observed that persons experiencing psychosis were better able to communicate their experience via the use of projective materials in occupational therapy, rather than solely through direct verbalization (Azima, 1961; Wittkower & Azima, 1958). The Azima Battery is based on psychodynamic and phenomenological principles, and is used clinically to understand the intra-psychic and relational functioning of individuals with psychosis, as an aid to case formulation and treatment prescription, to explore changes across treatment, and to establish a connection between therapist and client by offering them nonverbal and self-directed avenues for self-exploration (Azima & Azima, 1959).

The Azima Battery involves a standard setup and sequence of five tasks in three media: three pencil drawings, clay, and finger paint in conjunction with open-ended exploratory interviewing of the creations (Cramer-Azima, 1982). There was an initially proposed observational guide that was heavily steeped in the psychiatric language of object-relations (*ibid*), but this was never taken up clinically by occupational therapists (Zafran & Tallant, 2015b). Rather, the use of the Azima Battery within a phenomenological paradigm quickly

flourished clinically in contrast with the initial psychodynamic frameworks of a psychiatrist and psychologist (Cramer-Azima, 2012).

Unfortunately, very little research has been conducted on the Azima Battery since early forays in the 1960's and 70's (Thompson & Blair, 1998). These early studies provided preliminary support for the ability of expressive projective assessments to phenomenologically and metaphorically facilitate the expression and exploration of inner struggles and conflicts (e.g. Lawn & O'Kane, 1973; Llorens, 1967), and its use as an occupational therapy-specific tool for the analysis of activity performance domains (Sheffer & Harlock, 1980). The clinical contribution of projective assessments to case formulation in comparison to other evaluations (nursing checklists and an occupational therapy work evaluation) reveal that these tests add knowledge and depth to the understanding of the client in psychiatry, and aid in goal setting and intervention planning (Polatajko & Kaiserman, 1986). Finally, an occupational therapy study on the effect of the presence of the evaluator on the projective analysis confirms the need to include the exploration of the inter-subjective aspects of the evaluation process (Tallant, 1966).

Weber (2008) has outlined several reasons why the art productions of participants are desirable data; these include the belief that images capture the 'hard-to-put-into-words' of experience, that images enhance empathic understanding, and encourage the communication of extralinguistic subjectivity through metaphors and symbols. This belief that art can be studied for both meaning which may not be accessible otherwise, as well as the production of art as an aid to the (co)creation of self/other-knowledge, is fundamental in arts based research (Dewey, 1934/1980; Eisner, 2008; Higgs, 2008; Weber, 2008), expressive projective evaluations (Fidler & Fidler, 1954; Mosey, 1970; Rabin, 1981) and occupational therapy (Hemphill, 1982a; Thompson & Blair, 1998).

2.4.3. The potential of the Azima Battery in detecting early psychosis: evidence and experience

The literature indicates that diagnostic stability is achieved within the first year of onset of psychosis, with prospective consistency being highest for a diagnosis of schizophrenia (Chang, Chan, & Chung, 2009). As well, research demonstrates that difficulties in activity performance emerge prior to the development of a firmly diagnosable disorder (Jackson & Birchwood, 1996). Rehabilitation models do exist for intervention in the pre-psychotic phase of psychosis, prior to diagnosis (Woodside et al., 2007); and yet as outlined above, detection using verbal and behavioural indicators remains problematic (McGorry et al., 2003). Subjective, experience-based approaches to detection and diagnosis are more predictive than approaches based on objective observable signs (Klosterkötter et al., 2001; Møller, 2001; Nelson et al., 2008; Parnas et al., 2003). The Azima Battery offers such an approach.

Within the context of a program evaluation at the McGill University Health Centre (Zafran & Laporta, 2008), early evidence supporting the development of this study was retrieved from the medical charts of 12 persons receiving early intervention services in psychosis. These charts were reviewed for the following information: the psychiatrist's initial diagnostic judgment, the charted clinical impression obtained

through the use of the Azima Battery upon entry to the program, and the longitudinal confirmed diagnosis of the patient within one year or more. This pilot data demonstrates the superior predictive ability of the case formulation generated through the use of the Azima Battery (83%) in comparison to the psychiatrist's diagnostic intake interview (25%) (Table 2.1).

<Table 2.1>

This data was collected after the following experience: an occupational therapy colleague of mine working on the inpatient unit in psychiatry had been referred a 20-year-old man from the Middle East, whose clinical presentation was confounding and amorphous. Given the history of the institution as the place where the Azima Battery was developed, the young man was referred by the psychiatrist for an Azima Battery evaluation. This occupational therapist was new to the setting and requested that I conduct the assessment while she observe. Following the session, I walked the patient back to the unit. My colleague, thinking that she had taken up enough of my time, had already charted her impression that this was a young man with primary family conflicts who did not require further clinical follow up. I disagreed. I believed that he was on the brink of a psychotic break, or incipient schizophrenia. She asked me to explain my clinical reasoning and my interpretation. I found this very difficult to do despite my academic background and clinical experience with this assessment. I was unable to articulate my intuitive impression, beyond highlighting some elements in his narrative and creations, and left a brief note in his chart. I returned to speak to the patient the following day as he was being discharged, to explain where he could come should he start to feel worse. Less than two months later, he voluntarily presented during the early intervention clinical hours asking for me. He had begun to have auditory hallucinations in the three days prior, and the experience of the "*whole world falling into blackness*".

2.4.4. The projective evaluation case formulation in mental health

Mental health case formulation is an analysis that interprets the unfolding of the development of the individual's distress within their life situation, taking into account how they experience and express their problems (Winters, Hanson, & Stoyanova, 2007). Within this process of synthesis, psychiatric diagnosis is one of the hypotheses that emerges to answer the query 'what's wrong?' and is determined by the evaluator's dominant epistemological frame in clinical reasoning and in conceptualizing mental illness. As described above, the biomedical approach to labeling UHR youth and detecting incipient psychosis appears to not be as predictively valid as diagnostic interviews within a phenomenological paradigm. Yet, even the latter may be difficult to administer when the individual has great difficulty engaging in the verbal or conversational mode.

In providing an overview of the use of projective assessments and expressive media in the evaluation process, Reynolds outlines the distinctions between varying theoretical perspectives in the use and interpretation of an individual's projective profile for case formulation. She clarifies that the use of projective assessments is both medical-diagnostic as well as communicative and alliance building (Reynolds, 2008).

Although these dual aims may at times sit in uncomfortable epistemological tensions with each other, they are characteristic of the 'double vision' of occupational therapists whose clinical reasoning occurs within the 'blurred frames' of medical knowledge or diagnosis, and the phenomenological understanding of lived experience (Mattingly & Fleming, 1994).

The particularity of occupational therapists' clinical reasoning lies in the therapeutic and evaluative use of meaningful activities for case formulation. Our clinical reasoning has been empirically demonstrated to follow epistemologically very different simultaneous tracks (Mattingly, 1991b). Clinical reasoning 'blurs' between technical and procedural-deductive thinking based on medical or prescribed occupational categories, and the narrative or interpretive-inductive reasoning of the particularities and moral dilemmas in a given situation with a given client (Mattingly, 1998b). The art of clinical practice is the fluid navigation of these different modes of reasoning (Dreyfus, 2011) and the rigorous creation of knowledge to support them.

Therefore, in addition to the evidence and facts of procedural-diagnostic reasoning, an occupational therapist must be capable of 'narrative mind-reading' which is "the practical capability of inferring (rightly or wrongly) the motives that precipitate and underlie the actions of another" within their particular cultural and linguistic horizons (Mattingly, 2008, p. 137). These actions occur in clinical time, in clinical activity-based evaluations as well as in everyday lives. This form of narrative clinical reasoning has also been linked to experiential empiricism (Lanier & Rajkumar, 2013), phenomenological intuition (Braude, 2013; Mattingly, 1991b), and hermeneutic reasoning (Alvesson & Sköldberg, 2009).

While the rationale for the project is clearly outlined in evidence-based and traditional formats above, the underlying impetus for this study is that it called me and posed the questions: How did I know to use an expressive assessment, and what was my interpretive reasoning in detecting psychosis? How can I justify my conclusion of risk of psychosis with my 'occupational language' (Aiken, 2011, p. 298)? Am I usually right when I use the Azima Battery in mental health case formulation? I was faced with an address. "Addresses catch us off guard and break through our regular routines. They cause us to pause and take note, ask not that we speak or do something immediately, but rather that we stop and listen… Practitioners suffer these things in their practice" (Moules et al., 2014, p. 1 & 3). The ethics of framing research questions in this way is in line with the epistemological orientations to occupational therapy clinical reasoning, as well as the values of occupational therapy practice (Cook, 2001).

Evidence needs to be generated to support technical-procedural knowledge. In this thesis, this concerns the necessity of establishing the criterion validity of the Azima Battery projective assessment. In addition, two further points pertinent to this project are: (1) That the epistemologies of case formulation practices, or interpretive frames and ways of knowing in different evaluation approaches, be articulated and made visible (Kirmayer, 2012; Phillips et al., 2012; Stanghellini, 2007); and (2) there is a need for ongoing research on occupational therapy clinical reasoning (Unsworth, 2005). In particular, the continued refinement and illustration of narrative-phenomenological reasoning in the use of client-centered, activity-based practices (Mattingly, 2010a; Park Lala & Kinsella, 2011b), such as the Azima Battery.

Table 2.1: Pilot Data from Chart Reviews (N=12)

Age	Gender	Azima Battery Case Formulation at Intake	Psychiatrist's Diagnosis at Intake	Psychiatric diagnosis at 1-year follow-up
19	Male	Incipient schizophrenia	Drug-induced psychosis	Schizophrenia
19	Male	Schizophrenia	Bipolar disorder	Schizophrenia
19	Male	Drug abuse and psychosis in a young man with increasing psychosocial dysfunction and amotivation: at risk of developing schizophrenia	Drug induced psychosis	Schizophrenia
19	Female	Psychotic depression	Schizophrenia	Schizoaffective disorder
21	Female	Complicated grief reaction, severe anxiety	Psychosis Not otherwise specified (NOS)	Complicated grief reaction with anxious depression
21	Male	Primary anxiety with psychotic features. No perceptual dysfunction	Psychosis Not yet diagnosed (NYD)	Agoraphobia
23	Male	Schizophrenia	Depressive psychosis, rule out Obsessive Compulsive Disorder	Schizophrenia
23	Male	Schizophrenia	Obsessive Compulsive Disorder, depressive features	Schizophrenia
23	Female	Adaptation crisis with obsessive features	Psychosis NOS	Obsessive Compulsive Disorder
23	Male	Probable schizophrenia process	Schizophreniform	Schizophrenia
25	Female	Psychotic vulnerability in a young woman with childhood deprivation and relational issues	Bipolar disorder	Borderline Personality Disorder – Inhibited type
38	Female	First episode of psychosis in a woman with longstanding interpersonal difficulties	Psychosis NYD	Psychosis secondary to overuse of herbal pills in a woman with borderline personality disorder
Modal Ages 19 & 23	**Gender Ratio 7M: 5F**	10/12 matched description to long-term outcome **(83%)**	3/12 Accurate prediction of 1-year diagnosis **(25%)**	58% Schizophrenia-spectrum diagnostic outcome

Chapter Three: Research aims and objectives

The aim of this research is to (1) investigate the criterion validity of, and (2) explore and illustrate a phenomenological interpretive approach to, an expressive projective occupational therapy clinical assessment, the Azima Battery, with youth aged 15-35 years deemed to be experiencing the range of pre-psychotic to early in the first episode of psychosis.

The specific objectives are:

a) To situate the Azima Battery within occupational therapy history and practice in order to articulate the interpretive traditions it draws upon, and its clinical utility, by:
    i. Historically tracing the development of expressive projective assessments in North American occupational therapy
    ii. Establishing the evidence to date for expressive projective assessments
    iii. Exploring the opinions and clinical reasoning of senior experts in this domain of practice
b) To investigate the criterion validity of the Azima Battery with youth accepted into early intervention for psychosis services by:
    i. Estimating the predictive validity of the Azima Battery case formulation in predicting one-year psychiatric diagnostic outcomes
    ii. Comparing the predictive ability of the Azima Battery to the predictive validity of the attending psychiatrist's initial diagnostic impression
    iii. To describe and examine the elements of activity performance which are distinctive for a long-term diagnosis of schizophrenia
c) To explore and illustrate a phenomenological approach in the interpretation and case formulation of the Azima Battery with help-seeking youth by:
    i. Describing the structure of their experiences through their elicited narratives and expressive productions
    ii. Interpreting the meaning that they create of their experiences, and how this is expressed within the Azima Battery evaluation session

These objectives span different epistemologies and ways of knowing. Thus, a hermeneutic mixed methods research approach was designed to answer the research questions.

Chapter Four: Scaffolding a research practice

> "The only people who see the whole picture," he murmured, "are the ones who step out of the frame" (Rushdie, 1999, p. 43)

> "What the emerging discipline of occupational science requires is not a faithful commitment to a single philosophical foundation, but rather the capacity to engage ongoing dialogues within its epistemic community, to deepen philosophical discourse, and to embrace epistemological pluralism which is inclusive of knowledge claims informed by *different* philosophical traditions" (Kinsella, 2012a, p. 77)

4.1. Hermeneutic mixed methods

The Azima Battery is a clinical evaluation tool that offers a person-centered, intersubjective, activity-based process for therapeutic engagement and case formulation for help-seeking youth. It is therefore in line with recovery-oriented policy. The aims of the study were to examine criterion validity and explore a phenomenological interpretive approach to the Azima Battery. The methods used were both quantitative and qualitative. From a quantitative perspective, objectives were to validate the assessment tool, and to provide a descriptive profile of activity performance distinctive of a later diagnosis of schizophrenia. Qualitatively, the objectives were to explore and articulate a phenomenological framework for clinical reasoning and case formulation. To meet these aims an overarching hermeneutic approach to mixed methods was designed.

Mixing methods is an approach used in the development and refinement of instruments, where the "results from one method [are used] to develop or inform the other method" (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005, p. 226). This involves the use of both qualitative and quantitative methods and epistemologies to best address the aims of 'exploration' as well as 'confirmation' (Johnson, Onwuegbuzie, & Turner, 2007). In this study, all data was collected in a qualitative manner (e.g. historical, scientific or medical texts, field notes, and interviews). The term 'mixed methods' in here refers to the use of both multiple qualitative and quantitative strategies for the *analysis* of the various forms of data, including the transformation of one form of data into the other. Results are reported in both numeric and narrative types. This 'combinist perspective' is "a realistic approach to address the complexity of health care research, including occupational therapy" (Duncan & Nicol, 2004, pp. 454-455). The combining of multiple methods and analytic strategies requires an overarching paradigm in order to provide rigor in the integrative efficacy of the results (Teddlie & Tashakkori, 2009).

Hermeneutics is a philosophical practice of interpretation that fosters a pluralistic mode of reasoning for interpretive understanding in a multicultural world (Ricoeur, 1974). Being concerned with transitions, boundaries and connections, as well as the potential for (mis)understanding (Weininger, 1999), hermeneutics is based on an ontology of the in-between (Davey, 2006). That is, truth about phenomena emerges from between the connection between people (e.g. interviewer and participant), between the parts and the whole of a text (e.g. a transcript and across transcripts), or of a project (e.g. between the transitions of one method to another).

The use of hermeneutic modes of reasoning as an analytic strategy for combining the results of mixed methods research (MMR) has been demonstrated and illustrated in different ways that rest upon core Gadamerian metaphors for understanding (Van Ness, Fried, & Gill, 2011; von Zweck, Paterson, & Pentland, 2008). The primary rationale for the use of hermeneutics in MMR is the need to articulate and juxtapose the different pre-suppositions inherent in the various methods and ensuing results. This requires the acknowledgement of the historicity of both the phenomena under study and the researcher's worldview, in order to make visible where the horizons of meaning from the various results overlap, clash, or can be fused and expanded. Hermeneutics is epistemologically aligned with several key elements in this study. These are:

(a) The Azima Battery fosters knowing from in-between the participant, expressive tasks, and the occupational therapist

(b) The projective case formulation is the product of an interpretive reasoning process from within the occupational therapist's experiential, epistemological, and disciplinary horizons, from a certain historical context

(c) The need to examine and create an overarching reflexive analysis across and between the multiple methods and findings, in order to generate a rigorous and accountable final synthesis

Keeping this hermeneutic orientation at the forefront, the study design described in this chapter is chronologically ordered in terms of the data collection process for clarity, transparency, and reader comprehension. Data analysis occurred throughout and across the different methods between 2011-2015. However, the manuscripts in Chapter Seven and Eight are presented in the reverse order than that reviewed in this chapter. This is to maintain epistemological coherence. That is, Chapter Seven presents the embedded quantitative portion of the study, and thereby focuses on the ontic level of the findings. This refers to factual properties of a phenomenon and structures thereof (Dreyfus, 1991). The hermeneutic phenomenological analyses in Chapters Eight and Nine move the reader into the ontological sphere, to understand the existential issues of significance for the participants (Ginev, 1995), how these are revealed in the unfolding of the Azima Battery session, and the implications for clinical care.

4.2. Overview of study design

Study setting: The study was approved by McGill University's Institutional Review Board and approved by expedited review at the McGill University Health Centre (MUHC) and the Institute of Community & Family Psychiatry at the Jewish General Hospital (JGH). Further, the Director of Professional Services at the MUHC approved access to medical records. Four clinics agreed to participate in this study. The First Episode Psychosis (FEP) clinic at the JGH; the Program for Early Psychosis Prevention (PEPP) and the Early Psychosis and Intervention Centre (EPIC), both located at the MUHC; and McGill University's Mental Health Services for students (MHS). These four services are based in university-teaching hospitals, with interns present from all disciplines. The first three services offer specialized interdisciplinary approaches to

help-seeking youth and their families. The criteria for referral to FEP and PEPP are based on the UHR criteria. EPIC is a clinically oriented youth service that caters to adolescents and young adults early on in the process of psychosis (five years or less). MHS focuses on student health and their ability to remain in university; they are not a specialized psychosis clinic.

Study Design: The study was composed of five inter-twined and iterative parts, with their attendant methods.

1. Historically situating the interpretive practice of, and evidence for, expressive projective assessments in occupational therapy
2. Engaging in participant-observation data collection and qualitative analysis of Azima Battery evaluation sessions conducted in real clinical time with nine help-seeking youth admitted to the PEPP and MHS
3. The collection and statistical analysis of retrospective, medically documented reports and longitudinal diagnostic outcomes for patients (N=62) followed in EPIC and PEPP who had been assessed in occupational therapy with the Azima Battery upon entry to the programs
4. Conducting a sequential-exploratory embedded qualitative-to-quantitative analysis of the clinical sample (N=62) for the elements of projective activity performance distinctive of a future diagnosis of schizophrenia
5. Ongoing hermeneutic analysis of the overall research process and integration of these interpretations to offer an over-arching synthesis of the results

A brief overview of the methods used in each of these parts of the research is provided herein, to facilitate the reading of this thesis. Further details are found in the separate empirical manuscripts.

4.2.1. Critical history

The use of projective assessments in psychiatric occupational therapy dates back to 1950. In fact, this thesis is a new take on an old test. As per philosophical hermeneutics there is a need to historically revisit a phenomenon in order to understand it anew. Therefore, both the doctoral candidate and the supervising content expert (Dr. Tallant) conducted a search of historical documents and articles to trace the history and context surrounding the development of projective assessments in North America. This took place between 2011-2012. This history was interpreted in light of political factors affecting the desired legitimacy of the discipline of occupational therapy as well as swaying dominant discourses in psychiatry across the decades.

In tandem during 2012, a scoping review of the published evidence for the use of occupational therapy projective assessments was conducted. The results were updated in 2015. The results were interpretively synthesized to take into account changing practices and approaches in academic research, as well as the varying methodologies and epistemologies on which the research is based. The major shifts in the underlying ontologies of mental illness since 1950, through the 1980's-1990's, and once again to the current debates were analyzed in relation to how to understand this evidence.

Finally, I narratively interviewed nine experts in this field of clinical practice, each of whom had greater than 30 years of domain-specific experience. Interviewees shared their perspectives and experiences of the history and use of projective assessments, referring often to the Azima Battery. Themes related to research, training, and clinical reasoning, were also shared. These interviews were narratively analysed (Bruner, 2002), and along with the historical and scoping reviews, synthesized to provide clinical guidelines as well as avenues for future research (Chapters Five and Six).

4.2.2. Interpreting the case formulation and projective performance

A participant-observation strategy was used to qualitatively explore the unfolding of the Azima Battery evaluation session with youth accessing early psychosis services. The targeted sample was help-seeking youth aged 18-30 years deemed pre-psychotic by a psychiatrist and/or diagnosed with an as yet untreated first episode psychosis by at least one of the following UHR criteria.

Inclusion criteria: All participants were expected to be comfortable in English or French, and able to provide written consent. They were to be classified as having anyone of the following, as screened by the treating psychiatrist:

- Brief limited intermittent psychotic symptoms (BLIPS) occurring for less than 1 week
- A decline in psychosocial functioning and a first-degree relative with a psychotic-spectrum diagnosis
- A decline in psychosocial functioning and several second-degree relatives with a psychotic-spectrum diagnosis
- Potential prepsychotic features as assessed by an appropriate psychiatric measure (e.g. a psychiatric interview, or a rating scale such as the Clinical Assessment of At Risk Mental Status, Yung, Phillips, McGorry, Ward, Donovan & Thompson, 2002)
- Diagnosis of a first episode of mental illness has been made by a psychiatrist-led diagnostic interview based on DSM-IV-R criteria. Differential diagnoses may include any of the following:
    a. Drug-induced psychosis
    b. Psychosis Not Otherwise Specified (NOS)/Not Yet Diagnosed (NYD)
    c. Brief Psychotic Episode
    d. Schizophreniform
    e. First episode schizophrenia/schizo-affective
    f. Psychotic depression
    g. First episode mania with psychotic features
    h. Rule out personality disorders with micro-psychotic features

All participants were required to be eligible for early psychosis services at referral to research
Exclusion criteria

- Psychotic features secondary to a neurological process such as epilepsy, meningitis, concussion, brain tumour or other severe traumatic brain injury or disease
- In symptomatic and functional remission from psychosis
- Experiencing a second or more episode of psychosis
- Co-morbidity with severe intellectual handicap (IQ <70 as per psychological testing)
- Persons only transitioning in the Montreal region (i.e. no local residence)
- Homeless persons refusing clinical services for housing

Sampling Size and Process: Sampling of these youth aged 18-30 was purposive and sequential from the aforementioned Montreal-based services. The sample size aimed for was 10 participants for phenomenological analysis.

Recruitment Process: Psychiatrists working in the study sites were provided with a recruitment package that included the sampling criteria and a short summary of the research process, as well as consent to communicate forms (Appendices 1-4). Psychiatrists were to inform eligible patients that there was an opportunity to participate in research, and present them with a consent to communicate form. Individuals who signed an agreement to communicate were contacted by the doctoral candidate, and provided with further details. All potential participants were informed that they would be compensated for expenses incurred in participating (flat fee of $15.00 for travel and lunch costs). Twelve individuals were identified in the recruitment process, of which nine agreed to participate between 2011-2013. One was referred from MHS, the other eight were recent admissions to the PEPP. These nine participants were 18-28 years old, and consented to participate in a videotaped Azima Battery evaluation session. These evaluations were conducted by the doctoral candidate who was blind to the psychiatrist's initial diagnosis upon referral to the study.

Data collection

The Azima Battery was set up in a consistent manner for all individuals (see Figure 4.1). The participants were each asked to create five productions as follows: three pencil drawings (two-dimensional), that is, "Draw anything that comes into your mind", "Draw a person"; Draw a person of the opposite sex"; a clay object (three dimensional) that is, "Open the bag and take out some clay. Place it on the tile and make something in clay"; and a finger painting (two-dimensional with multi-step instructions), that is, "Take and wet the sponge and use it to wet the paper. Choose any colors you wish and using your fingers, do a finger painting". The participant is given as much time as they like, and then asked to free associate upon completion of each production. Open-ended, exploratory, non-judgmental questions were used to facilitate the expression of a narrative that centred on the participant's own articulated links between their productions, free associations, and their personal experiences. At the end of the session participants were asked to review their five creations, and to collaboratively reflect upon the themes shared and emergent meaning.

The time for each production was noted, along with detailed participant-observation notes about the interpersonal aspects of the session, the behavioral sequence of the creation process, any associations made during the production phase, as well as verbatim notes of the participant's associations throughout the entire session. An average Azima Battery evaluation session takes between 45 – 150 minutes to complete, although in this study sessions ranged between 80-240 minutes, including a debrief with the participants.

<*Figure 4.1*>

Case formulation and clinical analysis occurred within the week following the evaluation session for each participant. This was done for all the research participants prior to the collection of any diagnostic data

from the participant's medical charts, to prevent bias. A copy of the occupational therapy projective report was placed in the participant's medical record for clinical use by the treating psychiatrist and/or treating team.

Post-session memos that were intended to be a stream-of-consciousness brainstorming of the doctoral candidate's experience of the evaluation session were kept, to maintain fidelity to an inter-subjective epistemological orientation. An immediate memo was written right after the session, and further reflections added within the week, as sometimes allowing a few days to pass sharpens the verbalization of the experience. Post-session memos were completed prior to meeting the next research participant.

Three research assistants, one who was a licensed occupational therapist and two who were graduate students in a professional occupational therapy program, transcribed the videotaped sessions. These transcripts included the verbatim dialogue, time notations, notations for paralinguisitic and nonverbal communication (e.g. changes in posture, shift in tone of voice, changes in conversational rhythm), observations of activity performance, and sidebar clinical questions raised for the research assistants to help me further question my taken-for-granted or tacit knowledge in clinical reasoning.

Data analysis

I (the doctoral candidate) was immersed in viewing the videotaped data between 2011-2014, on an ongoing basis. The analytic framework for the qualitative analysis drew from both descriptive and hermeneutic phenomenology (Finlay, 2009). This analytic process, as well as the findings of this portion of the study, is reported in Chapters Seven and Eight of this dissertation. With respect to interpretive rigor, a reflection team was created to help promote my critical reflective capacity. This was a purposefully chosen group of experts who each contributed to the quality and depth of analysis in relation to their varying expertise at different stages of the research process through 2011-2013.

For the descriptive phenomenological analysis described in Chapter 7 (Mullen, 2007), four experts supported the process. An expert in psychosocial occupational therapy participated in the observation and descriptive analyses of the whole of the first three videotaped sessions (7 sessions; 28 hours). Further, two experts in measurement studies and occupational therapy iteratively reviewed the emerging descriptive themes for their clarity and suitability to convert them into numeric form (as described in section 4.2.4. below).

For the hermeneutic phenomenological analysis outline in Chapter Eight (Stanghellini, 2007), four experts from the realms of phenomenological psychiatry, occupational science and anthropology, psychosocial occupational therapy, and qualitative research, individually participated in the observation and analysis of the videotapes with the doctoral candidate (10 sessions; 19 hours). This involved reviewing selected sections of the videotapes that were deemed to be significant, striking or markedly different from the other participants in some way, and engaging in dialogue that focused on supporting or refuting my interpretations while reviewing the raw data. The experts also engaged in sharing their interpretations based on their expertise, and raising questions for further consideration in the data analysis. These individuals contributed to the maintenance of a reflexive stance, depth of interpretation, and rigor in qualitative analysis.

4.2.3. Diagnostic accuracy of case formulations

In order to answer the research question about the accuracy and predictive ability of case formulations generated by the Azima Battery, a quantitative approach was chosen. Following the same sampling criteria as for participant selection, a retrospective review of occupational therapy charts at the MUHC identified the charts of 61 individuals who met the inclusion criteria and who had undergone an Azima Battery evaluation with the doctoral candidate at entry into EPIC. These occupational therapy charts included the original Azima Battery projective report, the raw verbatim notes taken during the session, and four of the five productions (three drawings and one fingerpaint). For obvious logistical reasons clay products had not been conserved but were described in both the session notes and projective report.

Data collection

The medical records of the identified individuals were reviewed over the summer of 2013 for the following additional data: demographics (date of birth, age at entry into program, gender, immigration status), date and content of the psychiatric diagnostic report at intake (or if not available the most clear first diagnostic impression noted). The psychiatric diagnosis at 12-18 months, or longer if available, was also identified. Progress notes across the years were read and summarized in point form for significant events or changes. Additional psychosocial data such as occupational status at intake (such as details of participation in various activities), socioeconomic status, residential situation etc. were also extracted at both intake into services as well as at the time of final / most recent diagnosis as well as medical outcomes such as suicide. This longitudinal data was also collected from the medical records of the nine individuals who participated in the videotaped Azima Battery evaluation session (see Appendix 5).

Upon detailed review, medical records that met any of these exclusion criteria were removed if: (1) the Azima Battery was not setup in the standard manner, (2) the medical record details did not meet the sampling criteria, or (3) the projective assessment was not an Azima Battery. Eight of the 61 medical records were thus excluded. Including the additional medical records and data of the nine research-evaluated participants, a final total sample of 62 was achieved.

The data thus extracted was quantified into categorical scales with descriptors, with the exception of continuous data such as age or time delays. The Likert scales were ordered with either a 0 or 1 intending to convey least risk, pathology or dysfunction, and higher numbers indicating higher risk or illness impacts. The diagnostic categories were nominally numbered as per order in the most recent version of the DSM-5 (American Psychiatric Association, 2013) with schizophrenia spectrum disorders coded as 1 and personality disorders at the end of the numbered list.

Data analysis

The diagnostic accuracy of the occupational therapy evaluation and the psychiatrist's initial diagnostic interview were compared, in reference to their ability to accurately predict long-term psychiatric diagnosis.

The sample was then divided into those with, and those without a confirmed diagnosis of schizophrenia. Positive and negative predictive values as well as sensitivity and specificity analyses were calculated to estimate the predictive validity of the case formulation generated through the use of the Azima Battery. The same was done for the attending psychiatrist's initial diagnostic impression. The results and clinical implications are described in Chapter Eight.

4.2.4. Patterns of projective activity performance

There is an occupational therapy-specific interest in exploring observations of activity performance. Therefore, one of the research aims was to identify any patterns of performance in the five projective tasks that may be distinctive for a later diagnosis of schizophrenia.

Data analysis

Returning to the emerging qualitative results of the original sample of nine participants, a descriptive phenomenological approach was used to focus on the elements related to how they created and what they created during the videotaped Azima Battery session. A descriptive phenomenological approach is in line with an objectivist quantitative epistemology, and was, therefore, chosen for this embedded sequential exploratory section of the data analysis. That is, the creations were not analyzed for interpretive meaning but rather for the structure of the unfolding projective performance. The aim was to describe each process and product of creation in such a way that if a third party were to read the description they would be able to reproduce the drawing, clay, or finger-paint with some measure of accuracy without having seen the original, while bracketing out my assumptions of what the most salient features might be. This systematic and thorough process yielded several themes related to projective performance. Some of these themes-as-descriptive-categories overlapped with prior research on the topic while others emerged in this study.

These performance themes were treated as variables, and descriptively quantified into Likert scales, as above. These variables and descriptive codes were reviewed several times by three members of the supervisory committee for clarity, comprehensiveness, and logic of use in statistical analyses. Once a final draft was approved, a Microsoft Access data form was created for these variables. The projective performance data was then entered for the total sample of 62.

Given that the objective was not to create a scale to score the Azima Battery, but rather to identify potential patterns, the variables thus created were treated as nominal. Phi & Cramer's V correlational statistics were conducted to identify the performance items significantly associated with a final diagnosis of schizophrenia. These significant performance items were concatenated within each task and treated as 'strings'. Concatenation is the operation of joining nominal (qualitative) information end-to-end. In this case, the strings were created out of the numerical nominal descriptors of patterns of performance that were significant within each task, so that each subject had their own string pattern for each task. The frequency of each of these string patterns was calculated for those with, and those without, a final diagnosis of

schizophrenia. This was to identify if certain combinations of performance items were seen more frequently and/or exclusively for those with a confirmed longitudinal diagnosis of schizophrenia. These analytic processes, as well as the findings, are reported in Chapter Seven.

4.2.5. Hermeneutics

The overall intent of this study was not to conduct disparate methods to answer separate research questions surrounding the use of the Azima Battery, but rather to ensure an overarching process that explores and explains the clinical utility and validity of the Azima Battery when used as an initial evaluation process with youth admitted to early psychosis services. Therefore a double-hermeneutic process of over-arching and reflexive interpretive reasoning deepened the analysis of the different parts of the study (Ginev, 1998).

In order to facilitate this, field notes were kept throughout the active process of data collection. Participant-observation notes and reflections were taken during and after meetings when I was explaining and promoting the study to the sites approved by the McGill University Institutional Review Board, while waiting in the hallways to meet potential research recruits, while shifting between medical records and various clinician's offices to obtain medical records and/or to verify written information. These field notes also included historical details of the early psychosis movement, to help critically contextualize the creation of this specific clinical 'population', and were influenced by my involvement as an investigator on another research grant (Tranulis et al., 2011).

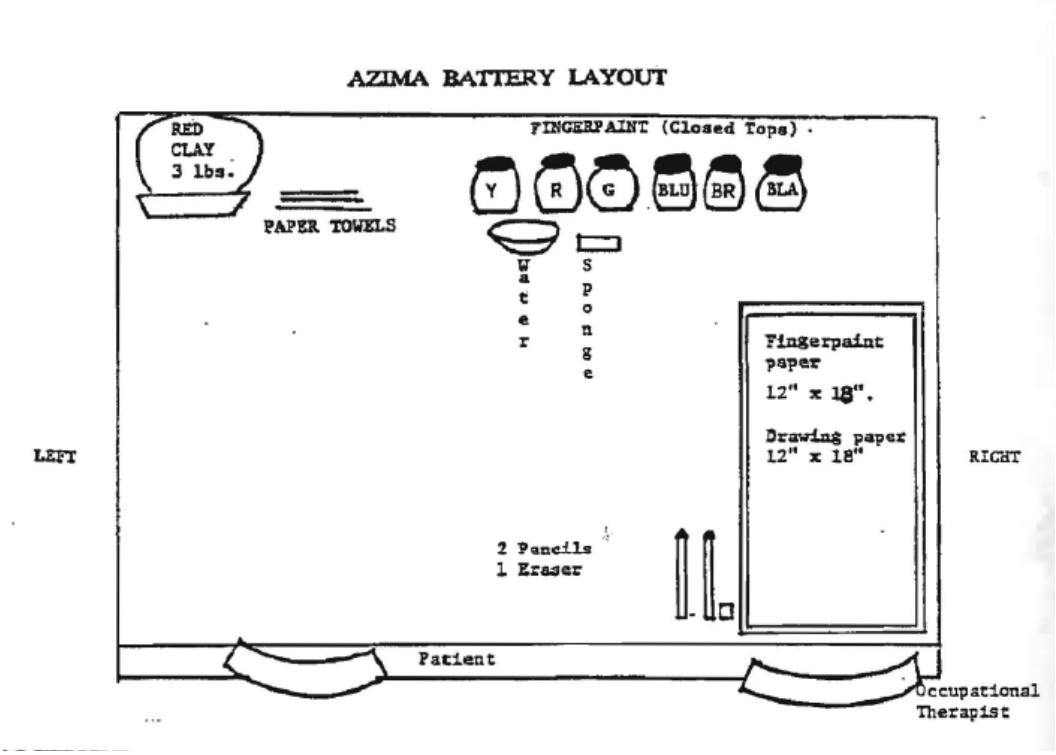
In addition, a research diary was maintained as of entry into the doctoral program. The research diary is a notebook in which I regularly wrote emergent ideas, concepts, links, emotions, difficulties and so forth, to promote the conceptual process and transparency of the whole iterative analysis and thesis-writing process (Engin, 2011). The diary included poems, metaphors and drawings or doodles of my research experiences, detailed participant observation notes of meetings with supervisors where difficulties and challenges highlighted taken-for-granted assumptions, the experienced moral and epistemological tensions as I transitioned from one part of the study to another, media clippings related to policy debates or early intervention in psychosis, and preliminary thoughts about findings relating to the whole research process (rather than the particular parts of the study). This diary facilitated the maintenance of a critical reflexive stance vis-à-vis the emerging results and helped in the articulation of my prejudgements and tacit knowledge about the research phenomena. Thus, reviewing the research diaries and field notes were part of the interpretative data analysis (Lincoln & Guba, 1985), and "enrich[ed] the study findings" (Laliberte-Rudman & Moll, 2001, p. 43).

I consider the ongoing dialogues with my supervisory committee and other experts related to this field of study as having been instrumental in refining my interpretive practice. There were challenges in our reflection team meetings due to the nature of an epistemologically mixed committee. These tensions were incredibly productive in naming and illuminating some of the key taken-for-granted aspects of projective assessments, as well as promoting a reflexive stance and justificatory rhetoric for a hermeneutic mixed

methods study design. Finally, I would especially like to highlight the discussions I had with the nine participants following completion of the video-taped sessions while accompanying them to ensure that they received copies of their consent forms. The reflections they shared about their experiences during the session, once we had left the room and the videotape was turned off, were noted as part of the post-session memos. They were significant in helping to articulate the potential utility of this approach from the perspective of the participants.

The synthesis of the results of the various components of the study, as well as what was hermeneutically revealed in the spaces and questions raised in the juxtapositions of these parts (in the in-between of the methods), is summarized and elaborated in the final discussion Chapter Nine of this thesis. In addition to critically appraising the clinical utility and validity of the Azima Battery, the interpretive framework for clinical reasoning and case formulation is firmly resituated within phenomenological and hermeneutic traditions. This raises serious questions about: (a) epistemologies for evaluation in mental health, (b) the contribution of occupational therapy to the reserved act of medical diagnosis (Office of Professional Orders in Quebec, 2013), and (c) the ontology of psychosis within the clinical reasoning of recovery-oriented evaluation encounters.

FIGURE 4.1: STANDARD SETUP OF THE AZIMA BATTERY
(Tallant, 2002)



Chapter Five (manuscript)

"It would be a shame to lose them"

A Critical Historical, Scoping, and Expert Review on the Use of Projective Assessments in Occupational Therapy. Part I.

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5.1. Abstract

Projective assessments have a long history in occupational therapy, yet their relevance may be questioned. This first paper reviews the clinical utility of projective assessments by providing a critical history of their development followed by a scoping review of the current evidence. The second paper outlines the opinions of nine experts in this field. Through this comprehensive process conceptual and methodological issues are articulated in order to suggest educational and clinical guidelines, and future research avenues. The place of projective assessments in occupational therapy is demonstrated as a salient specialty area of practice in the current evolving landscape of mental health.

Keywords

Expressive assessment, evidence-base, epistemology, therapeutic evaluation, psychiatric discourse

5.2. Introduction

There are vast changes currently occurring in mental health practice across Canada (Mental Health Commission of Canada, 2012), and the world(World Health Organization, 2012), which call for a mental health practice that is recovery-oriented, accessible, and empowering (Leamy et al., 2011). In this context, priority is given to approaches that value the individual's experience, culture, and voice, the quality of therapeutic relationships, the nature of engagement, and non-technological approaches to foster these(Bracken et al., 2012). Therefore, all disciplines are called to appraise their procedural tools in light of the evidence-base for these practice philosophies and values(Kirby & Keon, 2006; Petrova et al., 2006).

Projective assessments are the earliest theoretically informed and formalized therapeutic evaluation tools for occupational therapy in mental health. Occupational therapy evaluation tools using creative media were called 'projective' based on the underlying belief that the person "project[s] his or her personality into task performance"(Bruce & Borg, 2002, p. 95). The potential space for projective assessments in the current landscape of mental health may lie in their non-threatening, activity-based approach to evaluation and therapeutic engagement. "Creative or expressive arts assessments … enable therapists to enter the patient's subjective world more successfully and, above all, to communicate in greater depth with the patient and thereby build an empathic alliance"(Reynolds, 2008, p. 82). Such an approach elicits biographical information as well as an understanding of the client's personal meaning, which are both emphasized in recovery(Slade, 2009). The use of a projective assessment is particularly salient in the provision of recovery-oriented care to people whose expressive or communicative ability is compromised by illness, stigmatizing or traumatic experiences, or power differentials inherent in health care.

Although projective assessments have been in circulation for a long time, and hold useful possibilities in clinical practice, the use of formalized expressive media in evaluative activities is no longer as present in North American occupational therapy clinical practice (Schmid, 2004). Further, there is very little current research on these types of projective assessments and/or their clinical use (Reynolds, 2008). The aim of this two-part paper is to critically examine the historical, scientific and clinical basis for projective assessments. This is done with the clinician, researcher, and student in mind in order to contextualize and make contemporary how projective assessments are clinically used, appraised, studied, and taught in occupational therapy.

This review is composed of four sections. In this first article (I) we provide an overview of projective assessments and theory, a critical summative history of their entry into the domain of occupational therapy, and their perceived current status in clinical practice; followed by (II) a description of a formal scoping review of the evidence-base for occupational therapy projective assessments, where the results are interpreted in light of the broader field of research on projective tests as well as methodological issues in the research. In the second article we (III) outline and reflect on the opinions of nine experts who were interviewed on the clinical use of, and educational requirements for, projective assessments in occupational therapy. Philosophical, clinical, and methodological issues that have remained tacit over time are identified and

clarified throughout these three review sections. (IV) Finally, the reader is offered a comprehensive and critical synthesis in a discussion of future challenges and applications. Guidelines are suggested for psychosocial occupational therapy curricula, clinical practice, and research avenues for the ongoing development and use of expressive projective assessments in occupational therapy.

5.3. Section I. Projective assessments in occupational therapy

5.3.1. A brief introduction to projective assessments

The use of projective techniques in the human sciences can be traced back to 1895(Rabin, 1981), 1879 (Lilienfeld et al., 2000) or even 1876 (Kramer & Iager, 1984). Projective techniques were initially based on perceptual theories of cognition, and then on psychodynamic formulations of personality development. The term was first used in 1938 (Murray & Morgan, 1938), at which point the Rorschach Inkblot Test had already been in academic circulation for 17 years (Rorschach, 1921). For the purposes of reader clarification, a glossary of terms used in this domain is provided (see Table 5.1.).

< Table 5.1.>

Projection is the process of attributing qualities, feelings, attitudes and inspirations of one's own onto objects in the environment. Also, it includes the interpretation of situations and/or events by reading into them our own experiences and feelings, particularly when they are ambiguous, lacking in social referents, or a right or wrong answer or behaviour(Mosey, 1986). Projection is based on the assumption that people tend to view the world in an anthropomorphic manner. In so far as this view is colored by personal and cultural history, personality, and defensive or pathological traits or states, their projections will give clues into their intra-psychic functioning (Hammer, 1981)and what matters to them.

The creation and use of various projective tests and therapeutic approaches in psychiatry increased exponentially in the 1940's and 1950's, including in occupational therapy(Beran, 1955; Friedman, 1952; Vogel, Hanke, Miller, & Smith, 1950). This was accompanied by the attempt to formalize projective techniques in occupational therapy (e.g. Friedman, 1953; West, 1959). The first published standardized projective assessment in occupational therapy was the Azima Battery in Canada(Azima & Azima, 1959). This was reported in parallel with publications in the United States by Gail and Jay Fidler on occupational therapy as a diagnostic and evaluative process (Fidler & Fidler, 1954, 1963). The Fidlers created a Diagnostic Battery (Fidler, 1968)and later the Activity Laboratory(Fidler, 1982). A multitude of projective assessments now exist in psychology, art therapy, and occupational therapy.

"The essential feature of a projective technique is that it evokes from the subject what is in various ways expressive of his private world and personality process" (Frank, 1948, p. 47). The characteristics of a projective tool that elicit this rich insight into a person's world are: the ambiguity of the presented stimulus (e.g. inkblot, clay), the interviewee's freedom of responses, and holistic-ideographic interpretation, that is, an analysis of the 'whole' projective protocol (content, structure and process) that is individualized (Hammer, 1958; Lindzey, 1961; Rapaport, Gill, & Schafer, 1968). Projective assessments vary in the type of stimulus

(visual, media, instruction) and response (verbal, graphic, artistic) that they require of the participant, as well as the manner of test interpretation (numeric scoring vs. content-qualitative analysis). The following are the five types of projective assessments(Lindzey, 1961):

1) *Association Techniques* where the participant verbally associates to a visual stimulus e.g. Rorschach Inkblot Test (Rorschach, 1921).This is reported to be the only projective tool which meets the full projective test criteria (Rapaport et al., 1968)
2) *Construction Techniques* where the participant is requested to either construct a narrative in response to a pictorial vignette e.g. Thematic Apperception Test (TAT)(Murray & Morgan, 1938) or construct a specific drawing such as a Human Figure Drawing (HFD) (Machover, 1949)
3) *Completion Techniques* are usually based on the participant verbally completing the start of a sentence or story e.g. Sentence Completion Test (SCT) (Loevinger & Wessler, 1970)
4) *Choice/Ordering Techniques* require the arrangement of themed pictures e.g. the Szondi Test (Szondi, Moser, & Webb, 1959)
5) *Expressive Techniques*, such as painting, psychodrama and free drawings that stimulate creative expression and emotional reactions e.g. finger painting (Alleyne, 1980), Magazine Picture Collage(Lerner, 1979)

Types 1 and 3 require exclusively verbal responses from the participant; types 2, 4 and 5 require motoric involvement and some construction, free creation and open-ended discussion. From an occupational therapist's perspective type 5 assessments have an obvious advantage because of the client's involvement in an activity and the opportunity to observe their performance process. Expressive assessments are the predominant type of projective tool that were selected and developed in occupational therapy.

Projective materials have been used as evaluations in psychiatric occupational therapy to aid in psychiatric diagnoses and case formulation as well as change detection (Azima & Azima, 1959; Buck & Provancher, 1972; Fidler & Fidler, 1963), to uncover mental processes(Llorens, 1967), to determine the appropriate therapeutic activity (Androes, Dreyfus, & Bloesch, 1965), to formulate treatment objectives(Goodman Evaskus, 1982), and to engage the client in a therapeutic rapport (Reynolds, 2008).

The therapeutic value of projective assessments was recognized very early on(Azima & Azima, 1959). The process that arises in an expressive projective evaluation elicits the projection of the client's internal states in terms of their performance and final object creation. This initiates a therapeutic awareness in the client as he/she is confronted with the real objects that they have created(Saint-Jean & Desrosiers, 1993). Projective assessments may be used individually or in a group format to facilitate clients understanding of themselves, and to communicate with the occupational therapist and others (Eklund, 2002; Fidler & Velde, 1999; Lloyd & Papas, 1999; Reynolds, 2008).

5.3.2. The emergence of projective assessments in occupational therapy: A multiplicity of reasons

Much has been written about the psychodynamic roots of projective techniques in occupational therapy, which primarily emerged during the ascendancy of both Freudian and object-relation theories and practices in psychiatry (Thompson & Blair, 1998). The clinical reasoning underpinning expressive projective techniques in the 1950's is best expressed by leaders in the field: "Categorical diagnosis and prognosis should be known but are not necessarily of great importance within themselves. Diagnosis in terms of psychodynamics is of far greater importance" (Fidler & Fidler, 1954, p. 25). Bruce and Borg explain that this is an understanding of the client's attachment or relational style, emotional functioning, sense of self, layers of motivation and ego functioning, which all enable and affect occupational performance (2002).

Expressive media combined with projective theory afforded a psychological window into a client's internal world that would not be accessible otherwise. This led to the premise that one of the key roles of occupational therapy in mental health is to provide activity-based approaches to aid in diagnostic and functional evaluation (Fidler & Fidler, 1954, 1963). In addition, the interpretive lens provided by projective theory for the analysis of activity performance took on implications for non-expressive activities and other occupations as well (Fidler, 1957; Fidler & Velde, 1999; Rhéaume, 2006).

Certainly, object-relations theory is now a viable conceptual model for occupational therapy practice, and has been developed across time into an occupation-specific clinical and research base (Cole, 2005, 2011; Eklund, 2000; Mosey, 1970). It is also useful, however, to take a more critical stance towards this history, especially in the context of a female-dominated profession trying to validate its existence while experiencing sociopolitical tugs from various directions (Friedland, 2011; Peters, 2011). Published historical data reveals that during the 1950's the role of occupational therapy in mental health was simultaneously being both questioned and articulated in Canada (Azima & Wittkower, 1957)and the USA (Fidler, 1957). This was occurring because of the impetus for occupational therapy to align itself with medicine and its focus on disease and impairments (Friedland, 2011).

A Canadian government funded partial field survey of mental health professionals highlighted the lack of theory and educational knowledge of occupational therapy in psychodynamics and object-relations theory, as well as their poorly perceived inter-professional standing with psychiatrists (Azima & Wittkower, 1957). In the USA, the results of a national survey of 128 hospitals and expert consensus led by the American Occupational Therapy Association (AOTA) were published examining the roles and methods of practicing occupational therapists in their contribution to psychodynamic case formulation (West, 1959). As with the Canadian survey, the AOTA also noted that occupational therapists were spending much time observing and interacting with their patients yet this information was not being elicited by psychiatrists or framed in a useful manner. Of note was the ongoing caveat that occupational therapy's focus is not on diagnosis of psychiatric illness but rather on understanding the "patients needs…[and] the degree of health" (West, 1959, p.132).

Gail Fidler advocated for occupational therapy to develop training and language in order to "increase one's ability to state more specifically what can be achieved in occupational therapy and thus increase the

potential for communication with other disciplines" (Fidler, 1957, p. 9). In an interview with Dr. Fern Cramer-Azima, co-author of some of these early Canadian studies and publications, she explained that among the mental health disciplines at that time occupational therapists were lowest in terms of interdisciplinary professional regard, and that the aim was to find ways of including occupational therapist's perspectives and clinical observations within the psychiatric team: *"Object-relations was the name of the game…and they [occupational therapists] were spending many more hours with patients than anyone else so therefore they must have knowledge that must be tapped"* (Cramer-Azima, 2012).

A specific first step identified By Dr. Hassan Azima (a psychiatrist and psychoanalyst) and his wife Dr. Fern J. Cramer-Azima (a psychologist), was the lack of standardized, occupational therapy-specific evaluation tools in order to provide useful data about a patient's functioning.
"There was no standardized way of OT interviewing from the emotional point of view, they [occupational therapists] were using physical approaches" for evaluating daily functioning … Projective media were used to *"establish rapport, or to facilitate translation into action. It was an available way to tackle what was going on in the schizophrenic mind"* (Cramer-Azima, 2012).

Clinical observations made by the research group at the Allan Memorial Institute in Montreal, Canada, led to the development of both a dynamic theory for occupational therapy (Azima, 1961; Wittkower & Azima, 1958)as well as the development of the Azima Battery(Cramer-Azima, 1982). The aim of the Azima Battery is both diagnostic (in terms of psychodynamics) as well as to provide a therapeutic function. The Diagnostic Battery developed in 1964 (Fidler, 1968)used similar tasks to the Azima Battery, however, the attendant Outline of Evaluation was less psychoanalytical in orientation placing more emphasis on the production process and psychosocial communication. In 1965, Gail Fidler developed the Activity Laboratory for teaching and diagnostic purposes. The purpose was to elicit personality styles of performance as well as to promote the individual's self-awareness of how their responses are associated with daily performance of activities (Fidler, 1982; Fidler & Velde, 1999). Both the Azima Battery and the Activity Laboratory consist of five tasks in multiple media yet with different evaluative aims: The Azima Battery is intended to evaluate psychodynamic functioning while the Activity Laboratory is designed to assess domains such as motor, cognitive and social behaviors (Hemphill, 1982a).

Thus, the emergence of expressive projective assessments in occupational therapy occurred based on naturalistic evidence of what occupational therapists were actually doing and achieving, an activity-specific clinical rationale, as well as a professional-political context in which using the theories and terminologies of psychiatrists and psychologists legitimized this approach. An additional issue worthy of note was the potential for activity-based projective assessments steeped in psychodynamic theory to bring occupational therapy in mental health beyond a uniquely recreational focus and to place it on a par with occupational therapy in physical medicine and rehabilitation. This led to expanding curricula, clinical, and research foci to include the interpersonal and emotional dimensions of occupational and vocational functioning(Fidler, 1957). Guiding

the education and research of occupational therapists towards the predominant psychodynamic paradigm in psychiatry was both a theoretical as well as a strategic choice.

5.3.3. Contemporary practice

As biological and cognitive psychiatry have firmly taken over North American practice, the past two decades have seen a loss of expressive projective evaluations as an expertise integral to occupational therapy (Steward, 1996). This has occurred both in evidence-based occupational therapy curricula that streamline into entry-level MSc. programs, and in clinical practice. Another influence has been the devaluation of psychodynamic theories, with the rise of cognitive-behavioral therapy in psychiatry and its focus on the verbal, conscious and rational in adaptation (Thompson & Blair, 1998; Yakobina, Yakobina, & Tallant, 1998); and on clinical methods that are more amenable to quantifiable scientific research (Han Men, 2004; Lloyd & Papas, 1999). A poignant depiction of this loss can be seen between the first and second editions of *Assessments in Occupational Therapy Mental Health: An Integrative Approach*(Hemphill, 1982a; Hemphill-Pearson, 2008)– a key teaching text. In the 25 years between both editions, eight chapters and 15 appendices on projective assessments, including rich case material and images, were diminished to one summative chapter entitled 'Expressive Media'(Reynolds, 2008). This is particularly notable as the editor herself had created a self-named projective evaluation process for occupational therapy, the BH Battery (Hemphill, 1982b).

Further, a similar de-emphasis can be seen between the first (Asher, 1989)and second edition of Asher's *Occupational Therapy Evaluation Tools: An Annotated Index* (Asher, 1996). The section on psychosocial evaluations in the first edition includes three projective assessments, the BH Battery, Goodenough-Harris Drawing Test (Harris, 1963)and the House-Tree-Person Technique (Buck, 1970). The second edition does not have a psychosocial section and only includes one projective assessment, the Goodenough-Harris Drawing Test, reclassified as a cognitive assessment. Overall, the assessments selected for the 1996 edition reflect the then current theoretical frameworks of practice, which include behavioral and cognitive behavioral therapy, and the Model of Human Occupation (Kielhofner, 2008). The majority of the tests mentioned use standardized checklists to note observed behaviors and performance and self-ratings of self-esteem.

Certainly the practices and tools in psychiatric rehabilitation have expanded enormously with the shift towards community-based psychiatry, quantifiable evaluation tools, and evidence-based practice. In such a landscape concerned with outcomes, advocacy and policy (Mental Health Commission of Canada, 2012)the use of expressive media may seem frivolous and archaic. In occupational therapy, however, regret has been expressed about the loss of expressive approaches (Harris, 1997; in Thompson & Blair, 1998). More broadly speaking, the importance of subjective experience in the shaping of performance, satisfaction, and therapeutic outcomes, and even more so, the primacy of experience in meaningful occupation(Hammell, 2013), has taken an increasingly explicit place in articulating conceptual models for practice (e.g. Kielhofner, 2008) and occupational research methodologies (e.g. Cook, 2001; Hammell, 2007; Park, 2012). In fact, in contemporary practice and terminology, expressive projective assessments offer a 'window' into the person's lived

experience, values, and occupational identity, "a sense of who one is and wishes to become" (Kielhofner, 2008, p. 106). They also offer a window for therapeutic engagement and clinical utility in the rehabilitation process (e.g. Zafran, Tallant, & Gelinas, 2012)

5.4. Section II. Published evidence for projective assessments in occupational therapy

Given the rich historical roots, and potential clinical utility of occupational therapy projective assessments in recovery-oriented and occupation-focused approaches, a formal scoping review was conducted. Scoping reviews are used to explore and summarize the nature of research activity in a given domain of inquiry, as well as to identify gaps in existing knowledge (Arksey & O'Malley, 2005).

5.4.1. Search Question

What is the published evidence to date on the use of projective assessments as an evaluation process in psychosocial occupational therapy? Of interest in this scoping review was the level of evidence, client populations, and how projective assessments were, and are currently, used in occupational therapy. For a listing of specific occupational therapy projective assessments, the reader is referred to the first edition of *The Evaluative Process in Psychiatric Occupational Therapy*(Hemphill, 1982a).

5.4.2. Search Strategy

The following databases were searched on June 3-5, 2012, and May 29, 2015. These databases were searched both individually and in composite form: PubMed, PsycInfo, MedLine, HAPI, CINAHL, Web of Science, EBSCO, ASAP, SCOPUS, FRANCIS, ARTStor, ERIC, and BIOSIS. No restrictions were placed on publication dates. The following key words were used individually and in a combined manner: occupational therapy combined with each of projective, projective techniques/tests/assessments, expressive media/art/activity, and arts-based assessment. The addition of qualifiers to "expressive" and the term "arts-based assessment" did not yield further results in the first six databases (less than eight per database) and were duplicates. Hence these were subsequently dropped from the ongoing search strategy which focused exclusively on 'occupational therapy and projective', and 'occupational therapy and expressive' as keyword combinations in any field.

The total number of articles found in this manner was 1493, with an estimated 60% duplication rate across databases. An additional 47 articles were added to the results via a hand search of the reference lists in the book chapters and articles cited in the first section of this paper. As well, a specific search by name of researchers known to have worked and/or published in this domain (projective techniques or psychodynamic approaches to evaluation in occupational therapy) was conducted in the first six databases listed above, with an addition of a further pertinent four articles for a total of 1544.

These 1544 articles were deleted for duplications (n=985), and the resultant 559 articles were searched by title and abstract and sorted by the first author based on the following criteria:

Inclusion criteria: Articles were kept if they were research studies or conceptual papers on the use of projective media as an evaluation approach in occupational therapy with clients of any age or diagnosis. Both English and French papers were included.
Exclusion criteria: Articles on projective tests or assessments in psychology or art therapy were not included. Occupational therapy studies examining the use of projective or expressive therapy, or art as therapy or rehabilitation were also excluded from the final count (n=41). These two sets of excluded articles were maintained in two separate bibliographies to further contextualize the findings.

A final count of 28 English-language empirical articles on projective assessments in occupational therapy published between 1950-2015 were identified, of which 24 relate to the development of projective assessments and four use a projective assessment as an outcome measure (see Figure 5.1). These 28 were retained for critical appraisal and qualitative review. Figure 5.1 further outlines the number of conceptual or theoretical papers found and retained on the topic (n=13). Four literature reviews on projective techniques in occupational therapy were obtained. These four broad reviews on the use of expressive media in occupational therapy have been referenced in Part I of this paper and are re-summarized here as follows: (1) an unpublished thesis dissertation reviewing the use of arts in occupational therapy groups in mental health(Kavanagh, 1994); (2) a research project conducted for a graduate-level evidence-based practice symposium at the University of Puget Sound, openly available online(Han Men, 2004); (3) a historical and conceptual review contextualizing the shifts in paradigms and clinical psychiatric practice which have influenced the use of arts in occupational therapy(Thompson & Blair, 1998); and, finally, (4) an evidence-based critical appraisal of the use of expressive media by occupational therapists in mental health settings that used a convenience sample of 16 articles published between 1984-1994. These articles were found through a hand search of occupational therapy journals available at the authors' university library (Lloyd & Papas, 1999).

<*Figure 5.1.*>

An overview of the results of the scoping review is also provided in a chronological graph (see Figure 5.2.). This graph illustrates the historical rise and fall of projective assessments as described above. Empirical research on expressive assessments peaks in the 1970's with a steady decline as paradigm shifts occur towards biological and cognitive psychiatry. Expressive therapies follow behind projective assessments and peak in the 1990's just prior to the legitimate creation of art therapy as a formal profession (see Edwards, 2004). The relative lack of conceptual work and theoretical advancement on the administration, utility and interpretation of occupational therapy projective assessments after the 1950's is highlighted.

<*Figure 5.2.*>

5.4.3. Scoping review findings: Summary and critical appraisal

To our knowledge, this is the first methodologically rigorous scoping review (as per Levac, Colquhoun, & O'Brien, 2010)conducted on the evidence for the use of projective assessments in occupational therapy. It is unfortunate that in spite of several calls for the use of expressive assessments and

the first person-perspective in occupational therapy this scoping review cannot add much further to the four literature reviews on the topic, hence only a brief summary will be given here. This will be followed by a critical analysis and outline of the issues relevant to the scientific status of occupational therapy projective assessments.

Earlier text and journal publications between 1950-1980 were focused on establishing a theoretical foundation for the use of projective techniques from the psychodynamic perspective of the client relating to both the media and the occupational therapist (Fidler & Fidler, 1963; Lawn & O'Kane, 1973; Llorens, 1967; Malcolm, 1975; Miller, 1970; Weinroth, 1955). Research from this time period examined the development of assessments such as the Azima Battery (Azima & Azima, 1959) and other Diagnostic Batteries (Androes et al., 1965; Fidler, 1968). Researchers attempted to demonstrate the diagnostic and therapeutic use of projective assessments with a neuropsychiatric population across the lifespan (Llorens, 1963; West, 1959). These studies were based on naturalistic clinical reasoning and small sample case-based clinical observations. They were conducted in the domain of psychiatry, in the era of institutional and day care programs, with amorphous distinctions between medical diagnostic, occupational evaluative, and therapeutic aims.

A wide variety of media were used in evaluations, ranging from single to multiple media approaches. Common examples include magazine picture collage(Buck & Provancher, 1972), drawings (Sheffer & Harlock, 1980), finger paint (Alleyne, 1980; Vogel et al., 1950), clay, and sculpture(Azima & Azima, 1959; Shoemyen, 1970). These studies are almost exclusively presented within an object-relations frame of reference. Only a handful of studies attempted to examine the psychometric properties of projective assessments. These studies used simple pre-post or correlational test designs, or straightforward expert judgment -based discriminant validity. Sample sizes ranged from 10-150, with or without matched controls (Bendroth & Southam, 1973; Lerner, 1979; Lerner & Ross, 1977; Menks, 1973). A small number of attempts in the 1980's and 1990's were made to increase scientific rigor by shifting away from psychodynamic to more cognitive-perceptual or activity-based checklists and positivist measurement (e.g. Polatajko & Kaiserman, 1986). Clear summaries and critical appraisal of these can be found in Lloyd & Papas (1999) as well as Han Men (2004). No studies were found prior to 2004 that were not identified by these two reviews, and only a further three were found for the years 2004-2015.

While the historical bias in occupational therapy practice has been to use projective assessments in mental health settings, none of the three most recent studies are in the domain of psychiatry. One is a qualitative study (N=7) exploring typical children's understanding of time in relation to daily occupations through the use of drawings, interviews and rating scales(Minkoff & Riley, 2011). This study found that children preferred to represent their daily occupations through drawing rather than talking. The drawings were then elaborated upon with interviews. This data was corroborated by standardized rating scales, yet the qualitative drawing and interview approach gave richer, more in-depth, data about the children's temporal experience of daily occupations.

The other two studies are larger scale quantitative designs aimed at test validation. One study provides discriminant validity for the use of the human figure drawing as a screen for unilateral neglect in a neurological setting with 161 participants (51 participants with a stroke and 110 age-matched controls). The study correlates the classification scheme of the drawings with performance in activities of daily living(Chen-Sea, 2000). The final study developed and validated a scoring system for anxiety and depression also for a figure-drawing test, and demonstrated convergent validity with gold standard measures in a sample of 323 college students (Li, Chen, Helfrich, & Pan, 2011).

Overall, in terms of the quality of the evidence to date, the articles were graded along the convention that a level 1 study is of the highest quality in terms of study rigor and generalizability, down to a level 5, which is based on expert opinion with critical appraisal (Centre for Evidence Based Medicine, 2009). The current level of evidence for projective assessments in occupational therapy is at a level 2b, with the majority of research falling between levels 3-5. It is worth mentioning that the latter two most recent health measurement studies using figure drawings are at a level 1 of quantitative research evidence. At this point in time, while it may be superficially stated that there is an overall Grade B recommendation for the use of projective assessments (there is fair scientific evidence), it may be more accurate to suggest a Grade C recommendation. That is, to consider their use dependent on individual considerations. This is because, in addition to the small number of studies, the research is particularly difficult to generalize because of a wide heterogeneity in study populations, the specific occupational therapy projective assessment used, variability in study design and quality, and particularly methodological orientations.

5.5. Discussion: Reviewing the literature through a broader lens

Very early on leaders in occupational therapy advocated for multi-disciplinary practice and on sharing and building knowledge with others who use projective techniques (Fidler, 1957), such as art therapists and clinical psychologists. In clinical psychology, the use of projective techniques is almost exclusively in the area of formal testing rather than therapy. The projective tests used and studied in psychology are of the verbal association and construction (pencil drawings) varieties. There is an impressive body of rigorous research and journals dedicated to the topic, such as the *Journal of Personality and Projective Techniques.* In spite of the initial excitement over projective tests, and their current continued clinical use internationally (Piotrowski, 1984; Piotrowski, Keller, & Ogawa, 1993), empirical findings to date demonstrate highly mixed results for association and construction techniques(Garb, 2003; Singer, 1981). This positivist research was aimed at improving the standardization of test design, the development of theory-driven scoring manuals, empirical hypothesis-testing, and the establishment of norms with large sample sizes early on. The best known is the study on the Rorschach Inkblot Test (N=600) and was reported by Exner in 1974.

Rather than delve into the details of this large body of research, greater interest is placed here on the methodological and philosophical controversies that are better articulated within psychology as compared to occupational therapy about projective assessments. The main issues are (a) general questions around

diagnostic validity in psychiatric practice, and (b) the question of the relationship and rapport between the examiner and the interviewee. These two issues pertain to a critical understanding of the scoping review findings, and are summarized as follows.

If the primary clinical purpose is diagnosis, then this ties into critical questions about the nature of mental illness, diagnostic categories and classifications, their etiology, cross-cultural validity, and debates across time about the methods and psychometrics of diagnostic methods (Meehl, 1986; Phillips et al., 2012). This also begs the question, not just about the quality of studies prior to the mid-1980's, but also to their comparability to studies after 1984. A primary consideration is that the Diagnostic and Statistical Manual (DSM) underwent a radical shift in orientation from a psychodynamic theory to a purportedly atheoretical observable, behavioral approach during that time (American Psychiatric Association, 1984). With the publication of DSM-5 in 2013, debates over what actually constitutes mental illness continue to be heated (Phillips et al., 2012).

Art therapists, similar to occupational therapists, use a mix of construction and expressive projective tests. A meta-analytic review of assessments in art therapy was published recently(Chirila & Feldman, 2012). Their conclusions reference occupational therapy work (Heine & Steiner, 1986)and find that in art therapy, as in occupational therapy, the variety of assessments across 93 studies is wide ranging and, therefore, it is difficult to aggregate the findings. As well, 41 of these studies are based on clinical observations and reflections rather than rigorous research designs. This is similar to the situation in occupational therapy during the period 1950-1980, as art therapy has only, in this century, established a scientific orientation (Edwards, 2004).

What is especially significant in this particular reviewed body of research is that the theoretical focus in art therapy is an objectifying psychodynamic one. That is, the interpretation process in art therapy assessments seeks out signs and symbols that can be reliably and validly read for their unconscious or diagnostic meaning. This is a divergence from the occupational therapy approach to projective assessments which very early on followed the premise that "[p]henomenological evaluations are preferred over symbolic interpretations, unless clear associations are given by the client" (Cramer-Azima, 1982, p. 59). When asked in an interview what she meant by this, Dr. Cramer-Azima explained that: *"It is better for the patient to describe the experience they had, otherwise you shortcut the process…you have to let their narrative develop….Symbols are just a shortcut"* which may not necessarily represent the client's world or experience, and result in misinterpretation (Cramer-Azima, 2012).

The authors of the literature reviews in this domain of occupational therapy have all pointed out the discrepancy between (a) an exclusively quantitative research design that uses a scoring system based on symbolic content and quantification of behavioural performance, and (b) a clinical approach that relies on therapeutic rapport and the qualitative interpretation of an individual's lived experience as elicited and shared during a projective evaluation (Han Men, 2004; Reynolds, 2008; Thompson & Blair, 1998).

In projective assessments used by occupational therapists, the content, structure and process of creating objects and associations are all deemed meaningful and are interpreted qualitatively. Communication and understanding are enhanced because the participant verbalizes his own symbols and projections. Expressive projective assessments are "distinct from other projective techniques in that the temporal sequence of the process involves therapeutic as well as diagnostic values…The effectiveness on which it [self-expression by the participant] is so depends to a very great extent on the skill of the therapist" (Napoli, 1951, p. 387). Anastasi stated that projective assessments "serve as supplemental qualitative interviewing aids in the hands of a skilled clinician" (1982, p. 590).

In terms of the relationship between the examiner/therapist and interviewee/client, "[i]t would be an injustice to our patients to pretend that our clinical observations are completely objective" (Miller, 1970, p. 201). The interpretation of projective material is necessarily a subjective and qualitative process, which is the reason why quantitative approaches flourished in both psychology and to a lesser extent occupational therapy, to "safeguard" the objectivity of projective tests (Rapaport et al., 1968, p. 227; see also Ritzler, 1995).

This positivist approach is not consistent with the original theories upon which projective tests, especially expressive techniques, were based(Frank, 1948). "The primary legitimate use [of projective techniques] is non-psychometric; an interview focused on growth in various contexts" (Dana, 1975, p. 563). When these assessments are interpreted in a qualitative manner rather than being quantitatively scored, they offer special value to the clinical process(Anastasi, 1982). The therapist-interviewer was conceptualized as having to be qualified, with an expertise based on clinical experience, to interpret what patients made and said (Hammer, 1958; Llorens, 1967; Machover, 1949). Further, it was necessary to be able to understand how the therapist's own projections and reactions might affect the assessment and interpretation process (Alleyne, 1980; Azima & Azima, 1959).

In an early attempt to understand contradictory results in determining the diagnostic discriminant validity of projective drawings, Schmidt and McGowan studied the clinician-judges as opposed to the participants and their productions (1959). They found clinician-judges used different reasoning processes in interpreting the drawings: one group was labeled "cognitive" and used specific isolated signs to interpret drawings in a 'scientific' and 'intellectualized' manner. The second group was labeled "affective" and used an impressionistic, overall meaning and feeling approach to drawing and overall evaluation interpretation. It was the'intuitive' group that was able to successfully diagnostically sort the drawings, not the cognitive group, leading the authors to conclude that the type of clinical reasoning style significantly changes study results(Schmidt & McGowan, 1959). This echoes distinctions in procedural-deductive and narrative-interpretive clinical reasoning processes of occupational therapists (Mattingly, 1998b). With the exception of one study in occupational therapy (Tallant, 1966), the question of the relational process between the occupational therapist and the client has not yet been addressed in the research.

In terms of the limitations of this scoping review, it is likely that there may be further publications of interest that were not captured by this search. For example, if studies were published in non-occupational

therapy journals without the use of 'occupational therapy' in the title, abstract or keywords; or if a projective assessment was used as an outcome measure for a study but once again was not identified in the title, abstract or keywords (e.g. Bell & Stein, 1991; Levine, O'Connor, & Stacey, 1977). Conference proceedings were referenced in articles but did not come up in the online search (e.g. Beran, 1955; Tallant, 1966). In addition, expressive media with standard administration that are defined for use as an intervention modality, such as the Tree Theme Method (TTM) (Gunnarsson, Jansson, & Eklund, 2006) did not meet inclusion criteria. However, the first opening session of the TTM is described as an expressive evaluation. Another example of an evaluation not captured by this literature search would be the Kawa Model (Iwama, 2006). The Kawa Model was not developed as a projective evaluation, nor does it offer an observation of performance with unstructured expressive media, yet it certainly facilitates communication through symbolic and visual representation. Finally, discussions about projective evaluations embedded in occupational therapy studies focusing on object-relations or psychodynamic theory may not have been identified (for examples see Eklund, 2002; Eklund & Nilsson, 1999).

5.6. Concluding on the evidence to date

Through a critical tracing of the history of projective assessments and a rigorous scoping review of their scientific status, the epistemological and methodological challenges of studying projective assessments across shifting discourse in psychiatric practice have been highlighted. In part II of this paper, the findings of a qualitative study exploring the opinions of occupational therapists, deemed to be experts in the use of projective assessments, are presented. This is because a key element of the challenges identified herein is the focus on the notion of being an 'intuitive' or 'skilled' evaluator, and the relational dimension inherent in conducting and interpreting projective assessments.

The use of projective assessments in occupational therapy has remained a minor yet consistent presence in occupational therapy literature across decades and domains of clinical and research practice. This may be attributed to the romance of the arts, the nostalgia for an era of practice, a healthy respect for a rich history, and to the experienced clinical utility of projective techniques for both assessment and treatment. The literature reveals that although small, the conceptual base for the clinical use of projective assessments in occupational therapy has evolved from an exclusively top-down application of object-relations theories in the 1950's to a more eclectic, client-centered, humanistic and relational approach. Further research is needed to explore the educational preparation, clinical reasoning and skills required to enact this approach, and to validate the ongoing clinical utility of projective assessments in occupational therapy.

Table 5.1: A glossary of terms for projective assessments

Term	Description
Projective techniques	Global term used for assessment and treatment approaches that involve the use of vague or ambiguous unstructured tasks
Projective test	A personality test based on projective theory, with extensive psychometrics and norms
Projective assessment	An instrument or battery (series) of standardized tasks based on projective theory, without norms or psychometrics
Expressive assessment	Projective assessment used in occupational therapy involving the standardized administration of creative tasks with various media
Projective evaluation	The unfolding session as a whole process which includes the quality of therapeutic rapport and the client's ability to integrate feedback
Object or production	What the client makes as part of the occupational therapy projective assessment, e.g. drawings, finger paintings, collage, etc.
Object Structure	Composition and arrangement of component parts of the object/ and the manner of organization and construction of a complex whole.
Object Content	Theme and significance of the object to the client. It represents the meaning of a particular object
Associations or narrative	What the client spontaneously says and is elicited to elaborate about the object that they created during the projective assessment
Structure of associations	Pertains to the tempo and characteristics of expressed thoughts. Concerned with the composition and organization of thought process
Content of associations	Attributed meaning of what the client expresses about him or herself and his or her world
Projective material	Holistic consideration of structure and content of both objects and associations
Projective profile	Synthesized interpretation that the therapist renders about the evaluation session as a whole including analysis of projective material *and* the intersubjective process

(Anastasi, 1982; Anderson & Anderson, 1951; Asher, 1996; Azima & Azima, 1959; Hammer, 1958; Hemphill, 1982a; Lezak, 1983; Rabin, 1981; Rapaport et al, 1968; Stein & Cutler, 1998; Tallant, 2002)

Figure 5.1: Flowchart of results of scoping review: 1950-2015

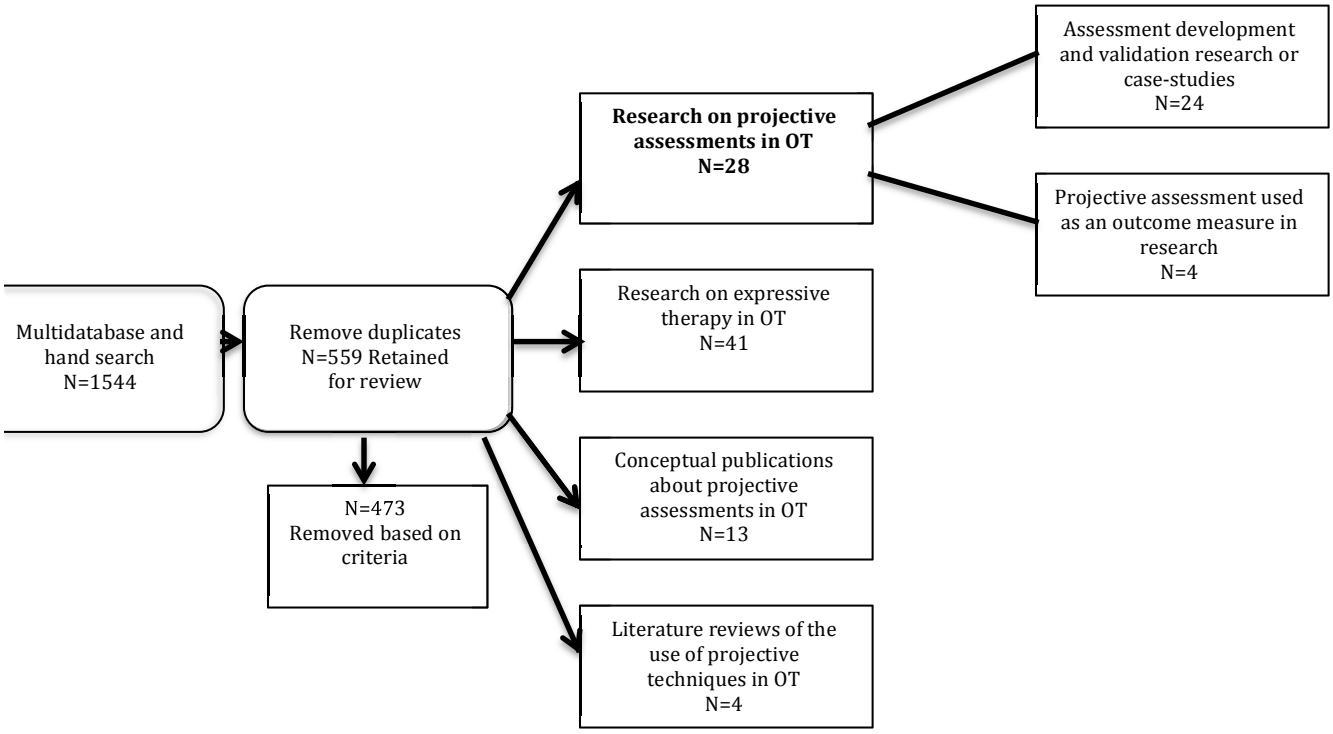
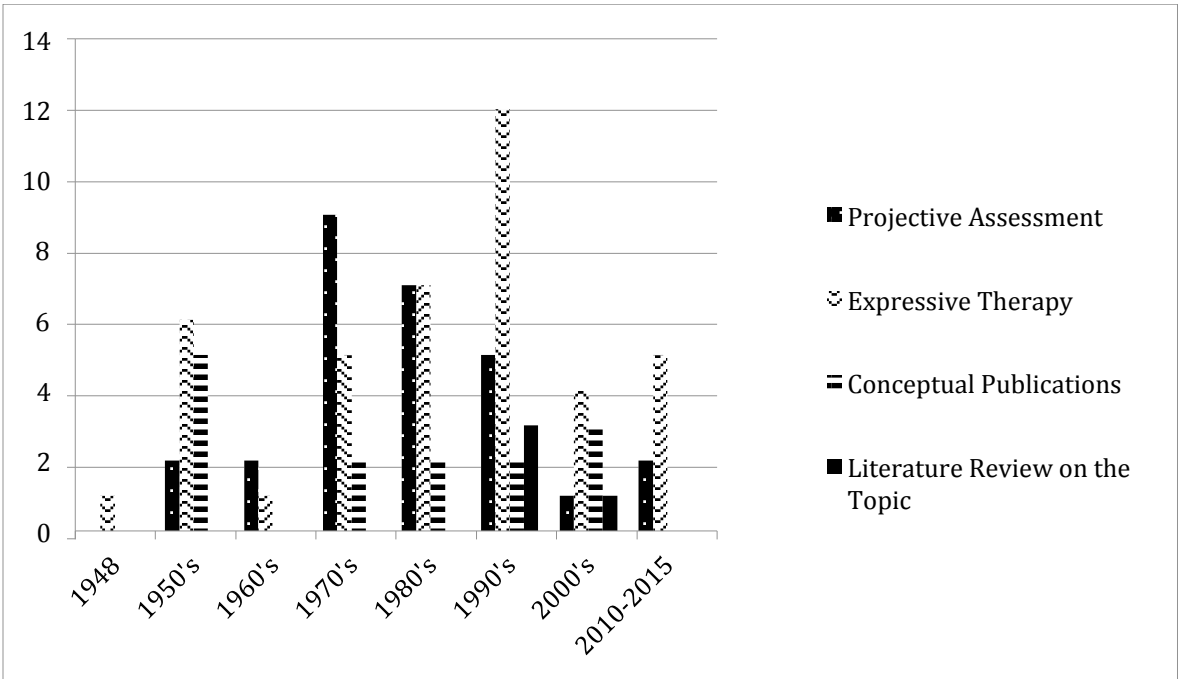


Figure 5.2: Publication trends, by decade, about projective assessments and expressive therapies in occupational therapy (N=86)



Chapter Six (manuscript)

"It would be a shame to lose them"

A Critical Historical, Scoping, and Expert Review on the Use of Projective Assessments in Occupational Therapy. Part II.

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6.1. Abstract.

Projective assessments have a long history in occupational therapy, yet their relevance may be questioned. Part I of this paper provided a critical history of their development and a scoping review of the evidence. This second paper outlines an interview-based qualitative study of the clinical and academic perspectives of nine experts. Through this comprehensive two-part paper, conceptual and methodological issues are articulated in order to suggest educational and clinical guidelines, and future research avenues. The place of projective assessments in occupational therapy is demonstrated as a salient specialty area of practice in the current evolving landscape of mental health.

Keywords.

Expressive assessment, professional competence, clinical guidelines, clinical reasoning, narrative reasoning

6.2. Introduction

Expressive projective assessments are the first formalized activity-based evaluation tools in North American occupational therapy. In these evaluations, art media is used to promote therapeutic rapport via creative modes of expression and communication, to offer an opportunity for the observation of expressive activity performance, to aid in diagnostic case formulation, and for change detection. Expressive assessments were developed in the 1950's, and were found clinically useful in both mental health and more broadly in addressing the psychosocial dimensions of occupational issues. Yet the scientific status of occupational therapy projective assessments has not matched their professed clinical utility. In Part I of this paper we demonstrated that the conceptual literature in this domain of practice has named the changes in psychiatry and the impact of this on expressive assessments. However, a critical perspective was required to address the sociopolitical context and epistemological issues in: (i) the historical development of occupational therapy projective assessments, and (ii) the rigorous and critical appraisal of the evidence to date.

In terms of their history, the clinical use of projective tests and assessments initiated by psychiatrists and psychologists had an underlying power dynamic whereby the therapist purportedly knew more about the client's issues than the client themselves, due to the therapist's ability to 'read' the client's unconscious motivations and conflicts (Bruce & Borg, 2002). This is not a comfortable fit with occupational therapy's client-centered philosophy. Thus, over the years, the clinical use of projective assessments in occupational therapy has ambivalently swung between diagnostic and therapeutic goals. Each of these goals may have different interpretive frameworks.

Therapeutic understanding was indeed synonymous with diagnosis prior to the Diagnostic and Statistical Manual (DSM)-III (American Psychiatric Association, 1984). This was when both understanding and diagnosis were based on searching for the psychodynamic 'why' of emotions, motivations and behavior (Luhrmann, 2000). However, this was no longer true during the subsequent three decades of biological psychiatry. Peters (2011) would name this an epistemological confusion, and highlight the need for a critical historical and contextual perspective when examining occupational therapy practices. Part I of this paper offers such a perspective.

A scoping review of the evidence for expressive assessments revealed that if one is to maintain a relational and qualitative perspective in line with the values and clinical approaches underlying this approach to evaluation, then one of the major challenges and avenues for studying expressive projective assessments is to capture the clinical reasoning and interpersonal stance of 'intuitive' evaluators (Schmidt & McGowan, 1959). The personal and professional opinions of occupational therapists about this domain of practice has been a source of knowledge in textbooks (e.g. Creek & Lougher, 2008; Reynolds, 2008). However, to our knowledge, no study has explored the expert perspectives of occupational therapists about expressive projective assessments in a methodologically sound manner. Therefore, in this paper, a complementary avenue has been taken, shifting from evidence-based practice to practice-based evidence.

6.3. Section III. Expert Opinions

Turning to expert judgment, or practice based evidence, is a useful approach when an area of clinical practice is lacking in scientific evidence (Liberman, Samea, & Rosa, 2011). "Service providers' individual clinical skills, in conjunction with the accumulated experience of colleagues, provide a valuable evidence base" (Centre for Community Child Health, 2011, p. 2). Expertise, here, is composed of extensive formal training and practice in the specific domain of interest, with significant years of experience (Rassafiani, Ziviani, Rodger, & Dalgleish, 2009).

6.3.1. Aim

The aim of this exploratory qualitative study was to elicit and understand the opinions of expert occupational therapists and key individuals on the development and use of expressive projective assessments in occupational therapy. Specifically, this study aimed to explore expert perspectives on the historical evolution, clinical utility and clinical reasoning used in the administration and interpretation of an occupational therapy projective evaluation. Further, this study sought to elicit opinions and beliefs about clinical approaches and the educational preparation needed for an occupational therapist to be able to use expressive projective assessments.

6.3.2. Sample

A purposeful selection of 6-10 occupational therapists deemed to be experts in the use of projective assessments in mental health was targeted. Purposive sampling is used to identify informants who can provide rich information with regards to the research question, and are selected based on the researchers' judgment (Teddlie & Tashakkori, 2009). The criteria for expertise in this study were: (i) having lived experience of the development of projective assessments in occupational therapy, (ii) extensive formal educational preparation in the use of such evaluation tools, and, (iii) practice in the specific domain of interest with greater than ten years of actual clinical experience (Rassafiani et al., 2009).

Given that the participants needed to meet all three criteria, they were sampled by word-of-mouth within collegial and clinical networks. That is, sampling began with individuals that the first author knew met the study criteria, and further potential individuals were identified and referred by these preliminary participants. This form of sampling, also known as snowball sampling, is useful when the participants being recruited may not be easy to find (Patton, 2002), such as for individuals having experienced specific, historically and geographically constrained events.

6.3.3. Data collection

This qualitative study of practice-based evidence was conducted in the province of Quebec, Canada. The interviews were semi-structured in an open-ended format, and explored the participants' past experiences with, and current opinions about, the historical, clinical, pedagogical and research aspects of expressive projective assessments in occupational therapy. The opening questions for the interview guide were generated with the research aim as a focus. These initial questions were refined by the first author and further questions formally added following the first three interviews, in an iterative process between data collection and

analysis. These opening questions (see Appendix 7) were subsequently maintained for the remainder of the study, although the order in which they were introduced varied dependent on the unfolding of the interview process.

The first author conducted the interviews between October 2011 and May 2012. The participants provided verbal consent and chose whether to remain anonymous or be named. The semi-structured interviews took place in people's homes over shared meals, and were between two to four hours in length. Notes were taken verbatim throughout in short hand as well as direct quotes, and reviewed immediately following the interviews. In addition, observational notes of the tone and process of the interview were taken as the interview unfolded, as well as in reflective memos following the interview.

<*Table 6.1.*>

6.3.4. Data analysis

Once all the interviews were completed, data immersion and repeated readings of the data occurred over the summer of 2012. Qualitative analysis of the interviews was grounded in Jerome Bruner's conceptualization of the term 'narrative'. He theorized that narrative was about the desire to create and communicate meaning, placing an elicited narrative as emerging from an experience across time (Bruner, 1990, 2002). Thus, the interview narratives were interpreted taking into account the historical context described above, and each interviewee's own expressed values and desires in their reasoning about the use of expressive projective assessments in occupational therapy. That is, for each participant, repeated readings of their opinions, combined with the observational field notes, led to an understanding of what was at stake for them (Mattingly, 2010a). The analytic process situated the participant's perspectives and beliefs within their described contexts of practice. This led to preliminary themes within each of the six interview questions. Follow-up phone or face-to-face conversations took place for further clarification and confirmation of the preliminary interpretations. After further data immersion and analysis, illustrative key quotes and stories were sent back to the interviewees via email for verification.

6.4. Findings

6.4.1. Participants

All nine individuals who were approached agreed to participate in this study. Eight were occupational therapists meeting the inclusion criteria while the ninth was Dr. Fern Cramer-Azima, co-creator of the first Canadian expressive projective assessment, the Azima Battery (Azima & Azima, 1959). The eight occupational therapists were all women with between 31 to 54 years of professional experience as occupational therapists in mental health. Five had an MSc or MA degree (all obtained prior to the shift to the entry-level MSc. curricula in occupational therapy in Canada), and one held a doctorate in psychology. Throughout the span of their careers, six were involved in university teaching, three held leadership positions within occupational therapy professional organizations at the provincial or national level, and four were dually

certified as both an occupational therapist and either as an art therapist or a psychotherapist. In addition to Dr. Cramer-Azima, four of the interviewed occupational therapists had also been involved in research on projective assessments in various ways (research supervision, part of a research reflection team, and conducting clinical research). Half of the clinical experiences were partly, if not completely, in child and adolescent mental health. Four of the occupational therapists continued to practice in mental health at the time of the interviews. Of the eight occupational therapists, five remained actively involved in dialogue with the first author throughout the process of data analysis.

In the following analysis of the experts' narratives, the terms projective techniques, projective tests, and projective assessments were used interchangeably by the interviewees, and therefore have not been changed in this paper. The focus of the interviews, and the qualitative analysis remain on occupational therapy projective assessments as defined in the Glossary in Part I of this paper (Table 2). All notable divergence in opinions is shared in this paper, as well as conflicts openly described by the interviewees. Some of the experts requested anonymity thus quotes were all de-identified and have been presented in an aggregate manner.

6.4.2. Why use projective assessments in occupational therapy?

"If you need a fast way to understand people"

Diagnostic clarification, or the more subtly expressed *"aid to case formulation"* was the first statement made by all the interviewees. They went on to explain that the diagnostic need for projective assessments in occupational therapy had diminished over the years. Whereas they attested to the fact that one can use a projective assessment to broadly distinguish between a person in a psychotic state compared to one in a neurotic state or with dementia, newer finely detailed diagnostic categories may be too specific for an occupational therapy projective assessment to capture (American Psychiatric Association, 2000, 2013). In addition, with the advent of newer generation medications over the decades, fewer clients remain in extended non-verbal or non-communicative states or with cognitive deterioration that precludes the ability to narrate a personal story or complete diagnostic checklists. Yet, in spite of these changes in clinical realities, the interviewees stated that they have continued to use projective assessments in their occupational therapy practice.

Interviewees explained that, in practice, projective evaluations allowed them *"to get to know a patient better, [in order] to help him"* and that an expressive projective process offered a *"wonderful window into a person"* or *"mirrors into their minds."* Every interviewee had at least one clinical experience to illustrate the depth of understanding one could achieve with a client within an hour. Two of these stories were written up by the first author and verified with the two interviewees. They are offered here as-is, rather than being paraphrased or reported as themes, to provide richer description for the reader.

"I have a vivid memory from very long ago. I was an OT in adolescent psychiatry,
and there was this teenager who in a verbal interview with his therapist had revealed

that he would wander the streets at night looking into the windows of people's homes. The psychologist was not sure if he was a danger or not. So I did an Azima Battery with him and right away it was evident. I was sitting next to him, to the right, like in the protocol, and he, with his hands full of clay, touched my cheeks, like this [interviewee demonstrates slow smearing motion pulling on the interviewer's cheeks] and he said: "You know, youth like me can do it". And like that, in one hour, I knew that this was someone who could act on his impulses and fantasies."

"I always encouraged the students to just try using projective techniques in clinical placements. One time, a student doing an OT placement in physical medicine had a client with a spinal cord injury who was not communicating much, so she did a projective assessment with him. I helped her with the interpretation, and she was able to give feedback to the team that this client was actually experiencing psychosis and needed to be treated. Somehow, the information had been lost that the reason why he was in a physical rehabilitation facility was for a suicide attempt. And there he was, in rehab, no one knowing what was going on inside him, that he was psychotic, and he didn't know how to express himself."

6.4.3. How has your use of projective assessments evolved over time?

"In those days we had so much to prove, not just to keep them [patients] busy. That's still a ghost"

When asked to reflect on the historical changes that have impacted the use of projective assessments in occupational therapy clinical practice, an honest and reflective dialogue occurred with all of the interviewees, filled with bodily tensions, emotions and sighs. Four of them contextualized their responses in a history not explicitly found in the published literature. They explained that, to their knowledge, expressive assessments were not initially created for occupational therapists or for intervention planning. Rather, the initial use of expressive media at the Allan Memorial Institute in Montreal was to provide a non-verbal method of longitudinally monitoring the impact of treatment with patients. This was a time when patients were treated using regressive de-patterning with electroshock, hormone or anaclytic therapies in the 1950's, and when long in-patient stays were combined with almost daily psychotherapy (Cramer-Azima, 1956). Human figure drawings as well as finger paintings were the primary media used in a non-standardized fashion.

The interviewed therapists had varying responses to this history, ranging from a practical attitude towards the evolution of psychiatric practice, to outright anger at an initially psychodynamically-focused process of reading the client's 'unconscious' which places the therapist in a position of superiority and power and *"takes something important away from the patient"*…*"places them in an ill-role"*. The interviewees went on to

explain that they had extended their reasons for using projective assessments over the years from a purely medical-diagnostic aim, to one of building rapport with a client with whom they would subsequently be working. None of these expert occupational therapists had changed the original standardized set up of any of the expressive assessments that they used, rather, it was their interviewing skills and intended use of the tool that shifted over time.

Five of the interviewees situated their reflections in terms of the broader issues of stigma towards persons with mental illness and the associated stigma of working as an occupational therapist in this (psychiatry) area of practice. This 'associative stigma' (Krupa, 2008) emerged particularly within a curriculum perspective. *"I have found it so hard to keep a focus on process and action in teaching"* in contrast to goals and outcomes in the era of evidence-based medicine. *"We teach students how to make splints and environmental adaptations but these are not primarily needed in mental health, why did we lose [stop teaching] projective techniques which we do need in mental health? Because of the power imbalance for [different] populations, and the stigma of psychiatric practice. It's been a failure for me as a professor. To keep the place of OT in mental health in a curriculum is always a fight. We never doubt too much things like anatomy."*

Several clinicians discussed the failure of research to legitimize the use of expressive assessments. *"The problem with evidence-based practice is that if it is over formalized, then you won't invent something yourself."* When thinking of what one could tell a student, based on research, one interviewee asked: *"Has the Azima Battery been revised over the years? When is the best timing for an evaluation? At the beginning? During a relapse? Or to use it as a therapeutic way of knowing someone? What about comparative studies? Retrospective studies? Cost-efficiency? When is it useful? … If it isn't standardized [referring to psychometric properties] no one listens."*

Some interviewees wondered out loud if the turn towards qualitative research in occupational therapy might address these questions in the future. *"I still wonder if in using projective tests we are being resistant to change, and then at other times I think [how come] we didn't invest in perfecting [this] competency [for occupational therapists]."* The challenges of finding both academic supervisors, as well as designing research, were acknowledged.

Overall, what these experts describe is that as a complement to being an aid to case formulation, the clinical value of occupational therapy projective assessments lies in opening up an understanding of the person and her or his illness experience, rather than their medical pathology per se. More specifically, expressive assessments were used to understand both the what and why of a client's presentations, motivations, values and interests and how this influenced their unique occupational process. For example, one interviewee often stated in teaching: *"a checklist or diagnostic tool may tell you that a client is depressed, but will not tell you what this particular client is depressed about*".

It is worth noting that, as in the vignettes above, in spite of advocating for the therapeutic use of expressive assessment, all interviewees shared several stories of using expressive projective assessments to distinguish in broad sweeps whether someone was experiencing psychosis or not; or to clarify if symptoms were –for example - in the context of pseudodementia or depression. When directly asked, perhaps their hesitation in committing to the diagnostic utility of projective assessments in occupational therapy comes

from a lack of current research evidence. As well, it should be noted that these interviews took place during a time in Quebec when new legislature was being introduced regarding the legally reserved acts for health care professionals working in mental health. A new bill had reserved the act of psychiatric diagnosis to psychiatrists and psychologists (Weil, 2009). A nuanced interpretation was subsequently issued following the adoption of the bill in September 2012, stating that case formulation of mental health issues and monitoring of suicide was the responsibility of all mental health professionals (Office of Professional Orders in Quebec, 2013).

6.4.4. With which clients would you use a projective assessment?

Unlike the other primary questions outlined in this section, disagreement is noted particularly in the domain of with whom to use projective assessments. Differences in opinion ranged from a clear statement that they should be used judiciously with complex clients, to *"in an ideal world you'd do an Azima [Battery] with every patient you had"* in order to obtain depth of understanding earlier on. Variation was also seen in terms of domain of practice. One interviewee stated: *"That OT is the same across populations is not true. Projective techniques is a tool we use in mental health, it may not be useful elsewhere."* Conversely, seven of the nine interviewees clearly outlined their belief in the utility of projective assessments from a broader psychosocial perspective with any client cohort or age, not just in mental health. For example, in detecting, eliciting, and understanding the anxious-depressive reactions in physical disabilities, relational challenges and meaningful desires in chronic conditions, the psychosocial consequences of degenerative conditions, and basically when any client has difficulty articulating his or her lived experiences or psychosocial issues.

One interviewee saw the benefit of using expressive assessments in certain areas of psychiatric practice (e.g. on an inpatient unit, with clients diagnosed with psychosis or dissociation). She felt, however, that such a method would be less pertinent with a client group where articulating experience and self-awareness is usually less of a challenge, for example in an adult anxiety program.

Another area of variation was in terms of the consultation vs. intervention role of an occupational therapist. Some interviewees believed that the therapeutic nature and extent of investment inherent in projective evaluations might only be worthwhile if this were a client with whom one was going to continue in therapy. Others highlighted the positives of such rapid depth of client knowledge when decisions and recommendations needed to be made in nebulous situations (uncertain precipitants, unclear case formulation), transfer to another setting, or interdisciplinary intervention planning. These circumstances might not all involve an occupational therapist beyond consultation. The differences in opinions may stem from the particularities and politics of each person's clinical and pedagogical practice experience and engagement. For example, those who agreed with a consultative role had worked extensively on inpatient units with pressure to make discharge decisions with clients quickly. Those who felt that the use of projective assessments should be limited as part of a longer term occupational therapy process usually worked in outpatient rehabilitation where the average intervention process ranged from months to years.

Where the nine experts did agree was in regard to the feasibility of using occupational therapy projective assessments across the life span in pediatric, adolescent, adult and geriatric practice, in either individual or in a group format. For example using a single task such as the Lerner Magazine Collage (Lerner, 1979), human figure drawing (Machover, 1949) or drawing of a tree (Buck, 1970) in a group. The majority preference, though, was for an individualized evaluation process. Seven of the nine particularly stressed the utility of expressive evaluations with children, adolescents and young adults. They explained that often these clients may be reluctant to share their stories with medical professionals, have developmental difficulties in reflecting upon and narrating their experiences, and are less inhibited with creative material. Other clinical indications about with whom and when to use expressive assessments revolved around the notion of complex clients who are unable to share their stories or reflect on their experiences in a clinically accessible manner for any of developmental, sociocultural, relational, cognitive or pathological reasons. In fact, these specific indications were consistently similar for all the interviewees even when their opinions about particular categories of clientele diverged, leading to consensus in the clinical reasoning around when to use an occupational therapy projective assessment. This finding is elaborated on further in the discussion on clinical guidelines in section IV below.

6.4.5. How do you interpret the media and session?

"I think we still haven't developed a language for our [clinical] use"

All the interviewees highlighted four central aspects in the process of projective analysis and clinical interpretation. These are: (1) to invest the time to think about the evaluation session and to iteratively find the layers of meaning and interpretation in the process. Even if a *"thumbnail sketch"* is clinically useful and can be provided without a complete report, the analysis takes time; (2) to be a reflective and emotionally mature practitioner who truly listens to the client and can distinguish between what is based on the client's process, and what is a projection or need of the therapist; (3) to be present during the evaluation session and not just examine productions after the fact, as *"You can't analyze it if you weren't there [in the session];* and (4) For the therapist to be well-read in pertinent and current theories and approaches.

"People find the interpretation challenging, because there is no right or wrong, it's not cut and dry…you need to think about it a lot." Some interviewees had, over the years, developed their own style and method of interpretation. Three based their approaches on the systematic reading of projective references, all citing *The clinical application of projective drawings* (Hammer, 1958, 1981) as a key text. All explained that basically, it's *"nothing really magical, it's another version of activity analysis and observational skills."* One interviewee had collected research-based methods of projective analysis across disciplines over the years, and combined with occupational therapy approaches to activity analysis, developed a systematic approach to analyzing the structure and content of the productions and the associations.

One participant described the tree drawing of a young man with schizophrenia who had had a serious suicide attempt resulting in significant bodily disfigurement. His tree was only a trunk with multiple

scars and no limbs. This occupational therapist clearly explained that, although the symbolism in the expressive media could be quite beautiful and evocative as well as emotionally resonant for the therapist, that one needs to resist the temptation to use symbolic equivalencies for interpretation: *"I didn't buy into analyzing the itty-bitty details for example the leaves of a plant mean…the curtains in a house mean… it's the gestalt that tells me [something about the person], and this may or may not add to the actual diagnosis."* Although some rating scales are available (see appendices in Hemphill, 1982a), participants explained that they were not designed to be used in a *"quantitative manner, but as a guide"* to the potential different observational dimensions. All interviewees insisted that it is the client who must create and confer meaning to their productions.

The interviewees explained that their interpretive lens had shifted and refined over the years based on their ongoing learning of theories of personhood and pathology within relationships. One explained that further training in psychoanalysis and play therapy helped her attend to the intersubjective aspects of the evaluation session. Another's development of expertise in cognitive behavioral therapy gave a different interpretive light to her questioning and subsequent analysis process. A third had gone on to study art therapy at the graduate level, while the fourth's grounding in art history and contemporary art allowed her to focus not on the content at all, but rather on the process, seeking the client's problem-solving, emotional and creative strengths for ongoing therapy. A fifth participant had studied family systems and focused on the client's relational history and style in occupations, and a sixth went onto use object-relations theories that had evolved based on present-day evidence from neuroscience and psychotherapy. Two of the interviewees had pursued training in the graphic arts.

Dr. Cramer-Azima discussed at length the need to understand projection in all its wide-ranging meanings across multiple fields. *"Consider the meaning of 'projection' in mathematics, in physics [e.g. a projectile], in film and cinema, in sales and marketing, in the latent imagery of TV and media, in packaging,"* in what one projects versus what is projected onto them. Thus, analysis needs to be *"integrated into the current body of knowledge [across multiple disciplines], to be able to place it [projective profile] in the pertinent frameworks of knowledge for therapeutic practice."* What all eight occupational therapists did stress was the need to then return back to home base and occupational therapy theories. For example, *"psychoanalysis has a deconstructive focus of analysis"* which takes things apart to examine deficits. *"Why look [only] at the impairment level"* when occupational therapy *"is about holism"*.

Participants all spoke of their therapeutic use of self in terms of eliciting narratives of experiences from individuals in distress via the use of projective materials. These occupational therapists were invested in grounding their particular use of projective assessments within the discipline's value of creating connectedness and engagement through occupation (Hasselkus, 2011). Also, they advocated developing an interviewing and interpretation style that maintained a client-centered approach to personal meaning and responsibility, as well as a strengths-oriented focus. In fact, terms used by eight of the nine interviewees were almost identical to recent literature on recovery-oriented care in mental health policy (Slade, 2009).

In summary, what emerged in the questioning around how each expert conducted the analysis of a projective evaluation session is that, in addition to seminal studies and publications on projective analysis

(Buck, 1970; Hammer, 1981; Machover, 1949; Rabin, 1981) and occupational approaches to activity analysis (Bruce & Borg, 2002; Lawn & O'Kane, 1973; Sheffer & Harlock, 1980), all interviewees supplemented their practice knowledge with further theories and philosophies. While particular theories varied with each interviewee, what they all had in common was the psychotherapeutic focus on eliciting and interpretively understanding experience in the context of a relationship, with interpretations made in light of occupational functioning. *"You need a frame of reference that talks about psychic functioning, that interprets the psychological emergence of words and images, within a therapeutic relationship, in a process of how change occurs."* Thus, all interviewees spoke of the therapeutic use of self, how to elicit a narrative that was not forthcoming or in awareness, and subsequently how to interpret the 'whole' of the evaluation session. This included what was created (without reliance on symbolic shortcuts), how it was created (activity performance), what was said (manifest narrative), how it was said (defenses, cognition, emotions, relational needs) and finally the occupational therapist's therapeutic use of self (counter-transference, relational experience of the session, interviewing skills). This practice echoes a seminal publication in this area (see Azima & Azima, 1959).

6.4.6. What kind of educational preparation would you recommend for clinicians?

"It was a brilliant group at the Allan Memorial Institute"

Unsurprisingly, all the interviewees stressed that projective assessments were a specialty process of occupational therapy evaluation, and that *"just taking one course [or workshop] is not enough"*. The following elements were all emphasized as part of the education which they had found useful for their own learning, as well as in teaching others: (a) strong theoretical roots, as outlined above, (b) on-going practice with clinical supervision, as it *"takes time to show this [process]"* and (c) engagement in collaborative learning with a peer group.

In terms of clinical practice-based learning, a distinction was made between the ability to conduct an occupational therapy projective assessment vs. to interpret it. The former requires skills in the therapeutic use of self and observation of activity performance while the latter requires mature self-reflection, and theoretical and empirical grounding. A main challenge identified was to find a supervisor or mentor, given that this is an area of practice that has not expanded readily over time. *"This is an area of OT practice where we need to remain open to interdisciplinary communication if we want to advance"*. Interviewees described learning with psychodynamically oriented clinicians such as psychiatrists, art therapists, clinical psychologists, other occupational therapists, professional artists, and psychoanalysts.

With a mentor, several strategies were described to foster practical learning. *"I model [demonstrate] it for the first time with a student, they take notes, and for the write up I give them report samples."* Ongoing feedback is provided. The next time, the student takes on the administering role with a new client while the clinical supervisor takes notes. Subsequently the student conducts a complete projective assessment simply with observation and feedback from the supervisor. *"[I was] allowed to experiment with supervision,"* which allows for the development of one's own style, the emergence of one's own strengths and weaknesses, and ensuing self-

awareness. Learning in therapist-client-observer triads was described both in clinical mentorship as well as in student university seminars. Here the observer provided an additional point of reference for the inter-subjective process, the student-therapist's interviewing skills, and aided in the subsequent projective interpretation in a paired learning model. In the classroom hands-on learning, students would video tape a complete session and analyze the various elements of the process in an iterative fashion. They would also then critically appraise the student-therapist's interviewing style for further learning.

The projective interviewing style needs practice, especially the use of open-ended questions. *"These [open-ended questions] only come naturally with genuine empathic curiosity about the other…meeting the Other needs experiential practice."* As well, integrating dynamic in-the-moment hypotheses about interpretive meaning into non-confrontational and well-timed questions takes practice with feedback. This is especially important if one takes a client-centered approach that wants to leave narrative meaning, problem definition, and resolution in the client's hands.

Other learning strategies were also described. *"I figured I needed to learn a lot more about it through using parts of the assessment as a group activity. [Once I did that], I then had lots of samples to look at. When I felt comfortable enough, I did an individual assessment…I also used medical students as 'normals'. Then they started referring patients to me."* The importance of simply doing many expressive assessments with clients was emphasized, and especially doing them in a standardized manner in order to maintain the face validity of the specific projective assessment and of one's learning curve. *"It's very important to do the assessment as it is supposed to be done [rather than] adapting the test out of existence… Even if it is subjective, go through the [administration] steps to be able to compare"* across clients, and along one's own learning curve developing competency with projective evaluations.

The importance of a collaborative learning environment was deemed an imperative for both novice and expert clinicians. Dialogue with others from either different disciplines or occupational therapists with different educational preparation helped to further expand one's theoretical learning and interpretive lens. *"We would meet daily between 4-5 pm to talk about [projective assessments], countertransference and transference issues and problem solve." "We would spread out the productions on the floor or table at the end of the day and gather round. The OT who had done the evaluation would give us an overview of the client, what they had done, and their associations*." In that process, the occupational therapist that had administered the projective assessment would begin to analyze and take notes for him/herself. The others would ask questions to refine the evaluator's critical thinking, to inquire about elements that they may not have noted, to help him/her critically reflect on her or his own potential projections or misinterpretations, and thus to help the occupational therapist to learn to see from both inside and outside of the projective experience. Thus the peer group also provided a reflective surface for the occupational therapist to become aware of interpretive and personal biases. This is a learning process characteristic of psychotherapy training that focuses on analyzing the client, the therapist and the unfolding process. *"Once you feel comfortable, you only come back to the group for really difficult cases, the complex ones, the really emotional ones."*

6.4.7. Why continue using occupational therapy projective assessments?

"It's a really quality intervention, it's a deeper sharing, it's taking the time to not just put a nice clean conceptualization onto someone… but actually listening to… the mess of people's selves and lives... It actually contributes to a person's healing."

All the interviewees, in spite of outlining the challenges inherent in this domain of practice, advocated for the maintenance of projective assessments in occupational therapy psychosocial practice. *"It's kind of sad in a way, just because it [projective techniques] reflects an era that doesn't really exist anymore, a way of relating and working with someone that has been replaced [by technical/procedural] rehab interventions."* These experts believe that *"you need to give the full package to the team and a patient: objective evaluations, subjective evaluations, and observations of performance."*

Training in this evaluation process *"helps you with observations in other tasks [as well]. It teaches you to recognize, to look behind the meaning of things"* and to appreciate and interpret the *"unfolding of a process between the therapist and the client, between the client and an activity."* Stories were shared about how projective theory helped the interviewees analyze groups and dynamics in various situations (e.g. forensic psychiatry, ecological catastrophes, and in student supervision). Several interviewees advocated for keeping projective techniques in occupational therapy curricula as a successful and important way for students to learn about therapeutic processes, as well as about themselves (e.g. Fidler & Velde, 1999; Liberman et al., 2011). Such instructional activities were described as an important psychotherapeutic opportunity for students to develop self-awareness when practicing projective assessments on themselves and each other, and thus to further develop their therapeutic use of self. The *"focus on analyzing mood, emotions, inner self…it's a common denominator [between therapists and clients]. How do we manage our feelings? How or why we do or don't get along with others. Humans attach. Why to this person or that one? Why would you not want to work with [a particular client population?]. To understand self and other's motivations...."*

In addition to developing the therapeutic use of self, such experiential learning also expands the interpretive lens onto these dimensions of occupational functioning. *"We have placed an accent on the output, wanting a generic model for OT…but the outcome [improved fine motor, classroom behavior] is not the same as the underlying problem"* or therapeutic process. The interviewees described a focus on meaning, and on understanding the client's process (in performance, relating, narrating), seeking their strengths and resiliencies, and *"naming their experience".*

"It [projective evaluation] does give you the phenomenology of how a person is experiencing their illness and life situation." Beginning with an expressive assessment in occupational therapy gives the client *"a place to be heard, especially in outpatient psychiatry"* as a complement to structured diagnostic interviews and medication-focused discussions with doctors. Beginning with an occupational therapy projective assessment can be a *"guide for therapeutic focus and goal setting in a client centered manner, because that is what they [the client] have come up with, and you can say 'what you have identified as your problem is'..."* Projective assessments were particularly described as a therapeutic lead-in to create rapport and in-depth understanding. *"I really see a projective assessment more as a*

treatment process...as the beginning of a long-term process where one takes the time to see [and work] with the patient, for example in vocational rehabilitation."

From a therapeutic perspective, projective assessments were described as key evaluation methods to access a person's values and desires, especially if they were not able to articulate or be aware of what is important to them. Also, from a strengths and wellness perspective, projective evaluations *"allow for the emergence of unusual material, … , but also for the emergence of a client's creativity."* These elements are clearly key to designing a meaningful and successful intervention plan in psychosocial practice.

In talking about why they continue to use projective evaluations, the clinicians used two different metaphors simultaneously. One was an analogy of the detective story, and that projective assessments lead to "*clues*" about a person's inner world. These clues allow the occupational therapist to generate a clinical impression about the inner self's emotional and relational domains of occupational functioning. Which parts of the client's psychosocial history are salient to understanding their daily adaptations? The detective story, and clue finding was intertwined with a second metaphor, that of embarking on the beginning of a journey with the client. In addition to functional clues, a projective evaluation process supports the occupational therapist's ability to understand the client's dreams, hopes, desires, fears and experiences with significant others. The form of the evaluation process also promotes the creation of therapeutic rapport with clients who have psychosocial difficulties in communicating and/or relating, and thus help to collaboratively design and engage in a meaningful intervention journey. These two approaches, that is, finding clues from which to deduce or derive functional issues, and interpreting for the particularities of meaning, have been described in occupational therapy clinical reasoning as procedural and narrative reasoning (Mattingly, 1998b). As well, the metaphors of detective sleuthing and meaningful journeying have been identified as distinctive narrative genres of hope in clinical care (Mattingly, 2008, 2010b).

The interviewees were all clear about the ongoing value of projective assessments in terms of contributing to mental health case formulation (and for some even diagnosis), in analyzing emotional-relational aspects of occupational functioning, and as a therapeutic process of communication between self-self and self-other, for both students and clients. These nine experts believed that projective assessments provided a creative space for the client's voice to be facilitated and heard. At one point or another during their interview, seven of the nine experts made the following statement (five in identical words): "*It would be a shame to lose them.*"

6.5. Discussion: Concluding reflections on expert clinical reasoning

> "Maintaining a balance between the medical and phenomenological practices is a delicate challenge; this balancing act may be *our* [occupational therapists'] crucial task"
> (Hasselkus, 2011, p. 137)

The primary finding in discussions with experts is the potentially uneasy distinction between the diagnostic and therapeutic aims of projective evaluations that has emerged across shifting psychiatric

discourse. Much of the divergence of opinions noted in the interviews can be attributed to this divide, which is rooted in the historical and paradigmatic contexts previously outlined in Part I. For example, when negating the potential use of expressive assessments as part of a consultative role as an occupational therapist, interviewees were speaking to the therapeutic value of such evaluations and the need to be delicate with this. Conversely, when advocating for the use of occupational therapy projective assessments to evaluate performance components such as ego functioning and mental states such as psychosis, interviewees were speaking to their diagnostic utility. Being explicit and clear about the intended function of a projective assessment is a prerequisite in any conversation or decision-making about its use in clinical practice.

In offering a 'window' into a person's experiences, occupational therapy projective assessments naturally straddle the tension between what has been described as reductive vs. holistic paradigms (Wilding & Whiteford, 2007; Yerxa, 1993). That is, a therapist can be pulled either towards reducing and classifying an individual's shared narrative and projective performance into categories of illness or deficits, or interpretively understanding a client's lived experience and what is revealed as meaningful to him or her in the expressive process. Therein lies the complexity and depth of the clinical utility of such an approach to evaluation. Indeed, in many ways, a *"language"* for the clinical reasoning that underpins the integrative synthesis in a projective profile can be said to remain 'underground' (Mattingly, 1998b).

The procedural reasoning (Mattingly & Fleming, 1994) that examines the components of a projective evaluation session for 'clues' about a person's strengths and deficits has been well-outlined in the literature in key texts. For example, checklists have been developed to guide observation of performance in projective assessments (see appendices in Hemphill, 1982a). These can also be found in the multiple editions of Hammer's seminal publication (1958), and others (Buck, 1970; Wenck, 1970). This leads to an interpreted profile of the structure of a person's projective performance. Although the content of objects and associations are important, the emphasis in the diagnostic aim of projective assessments is on the 'how' or structure as this is understood to reveal core elements of the client's overall psychic functioning (Lezak, 1983; Rapaport et al., 1968; Tallant, 2002).

On the other hand, the narrative reasoning involved in interpreting a client's lived experience through the use of an expressive assessment has been limited in the literature to focusing on the meaning that a client confers on the content of his or her objects through their associations. In listening to these experts it is argued here that the extended empirical definition of narrative reasoning is a key facet of conducting and analyzing an expressive assessment. This form of reasoning involves the therapist's skill in interpreting what is at stake for a particular individual, as revealed in *both* their stories and their expressive actions. It is the therapist's ability to understand and connect across sociocultural difference (narrative mind-reading) in order to establish therapeutic rapport through empathy and understanding, to attend to the experiential and aesthetic aspects of sessions, as well as the moral and intersubjective dimensions; and finally, narrative reasoning is also involved in meaningful prospective story-making with a client (Mattingly, 1998a, 2008, 2013). This form of reasoning is central to a therapist's skills in setting the therapeutic aims of occupational

therapy projective assessments and was revealed within the illustrative stories that the experts chose to share. Yet, no explicit mention was made of how to learn this except through practice and experience. Thus, this skill remains a significant competency to be articulated for occupational therapy.

In addition, it is argued here that narrative reasoning is not just involved in the therapeutic value of projective assessments; it also fosters the efficacy of the diagnostic function by allowing for more in-depth "recogni[tion of] a physiological body which is inextricable from the imagined and lived body, the body which carries a person through social space and time" (Mattingly, 1998a, p. 22). This recognition is what can bridge the divide between the dual aims of occupational therapy projective assessments and echoes the long-ago call to make transparent the clinical reasoning that has sometimes been viewed as the more discriminatory diagnostic reasoning of 'intuitive' clinicians (Schmidt & McGowan, 1959).

A final reflection concerns a return to the imperative for a 'phenomenological' approach to projective evaluations that was espoused by the interviewees and an original framing for expressive assessments as a mode of communication and understanding (Cramer-Azima, 1982). Phenomenology is an in-depth approach to understanding human experience. Descriptive phenomenology aims to explicate the structure of experience whereas interpretive phenomenology focuses on meaning (Finlay, 2009). The empirical development of narrative reasoning has occurred within a phenomenological approach to research (Mattingly, 2010a). Thus, based on an analysis of these expert's narratives, phenomenology may be a promising approach within which to situate, promote, and create new evidence for occupational therapy projective assessments.

A limitation of this qualitative study with experts includes its historical and geographical specificity. Montreal is a Canadian center point for the creation and development of occupational therapy projective assessments. Therefore, while providing a sample of clearly knowledgeable experts, if data saturation is to be aimed for one might be interested in interviewing occupational therapists from differing locations and contexts who may have developed a different approach to using and valuing expressive projective assessments. In addition, other occupational therapists in Montreal belonging to a younger generation of experts (less than 20 years experience) did not participate in this study due to criteria focused on attaining a historical perspective. Nonetheless, a second generation of younger experts may have shared different educational preparation, opinions and perspectives. Finally, as an emerging expert herself, the interviewer (first author) knew six of the nine participants prior to the study. This certainly facilitated the intimacy and sharing during the interviews yet may have also led to 'blind spots' in the questioning and exploration process because of taken-for-granted assumptions as to what was actually said or meant by an interviewee.

6.6. Section IV. Future applications and challenges for occupational therapy projective assessments

6.6.1. Clinical considerations

Occupational therapists inclined to use projective assessments in clinical practice face certain challenges. These include justifying their use in the face of current heterogeneous scientific evidence;

negotiating the contested overlapping terrain between occupational therapists, clinical psychologists and art therapists; obtaining sufficient educational preparation and supervision to develop clinical competence; and reformulating the clinical reasoning and use of such tools in an era of community-based, recovery-oriented care. The following clarifications, suggestions and clinical guidelines are built from sections I-III of this two-part paper, as well as the clinical and research experiences of both authors.

Expressive projective assessments in occupational therapy are one type of subjective evaluation, such as client journals and semi-structured occupational interviews (Kielhofner, 2008). As such, there are challenges to their use. The evaluator's skill in administration and interpretation is one important factor. Another important consideration is the lack of 'fit' of an expressive projective assessment with a client who would not accept to engage in an arts-based activity. Finally, psychometric properties such as reliability are a moot point given the qualitative nature of expressive evaluations; however, validity studies have demonstrated preliminary evidence for their use in case formulation (Chen-Sea, 2000; Li et al., 2011).

In spite of these challenges, the utility of occupational therapy projective evaluations lies in their qualitative, subjective nature, although it would be more accurate to say that they are intersubjective evaluations. That is, projective evaluations involve the co-creation of meaning with a client, in an interplay between the experiences of the client with the expressive media and therapist, and the experiences and ensuing interpretations of the therapist (Kossak, 2009; Raskin, 2001). This involves a balance between the world of one individual (the therapist) and the otherness of the client's world (Jackson, 1998), modulated by the projective tasks.

Finn & Tonsager (1997) define information-gathering models of assessment as focused on obtaining reliable, factual, usually medical, data about clients for clinical decision-making. They contrast these to therapeutic models of assessment whose major objectives are to establish therapeutic rapport, to collaboratively develop a narrative understanding of the client's lived experience, and to initiate the process of change in clients with complex presentations and histories. It may be strategic and clinically useful to consider occupational therapy projective assessments as straddling both information gathering and therapeutic models of evaluation (see Aronow, Reznikoff, & Moreland, 1995; Raskin, 2001 for analogous arguments in psychology), with an accent on the occupational implications of projective profiles.

From an occupational therapy perspective, such an intersubjective evaluation focuses on eliciting and exploring psychosocial, cultural, emotional, and relational aspects of occupational identity and occupational functioning from the perspective of the client's inner world and process. A client's ideals, values, interests, fears, coping or defensive style, ability to relate and attachment style (Meredith, 2009; Meredith, Merson, & Strong, 2007) would emerge and be collaboratively reflected upon as therapeutically appropriate. The client's ability to engage in such a potentially intimate process affords a complementary way to know the client, leading to rapport and client-centered goal setting. The notion of therapeutic interviewing is well established in psychotherapy and qualitative research, as sharing "[s]tories may offer a prime avenue for healing itself where healing is defined, in part, by a recovery of the self" (Mattingly & Lawlor, 2000, p. 5).

In occupational therapy media-based projective evaluations, there are two added layers that are crucial to note. The first layer in expressive assessments is that of observing elements about the experiential structure of pathology or illness as revealed through the client's projective activity performance that are not readily reflected on or deduced from verbal interviewing. For example, in the early phases of schizophrenia, an individual may develop obsessive thoughts and habits (van Nimwegen et al., 2008). These need to be differentiated from a diagnosis of obsessive-compulsive disorder (OCD). While difficult to differentiate in a verbal interview, the performance of an individual with OCD on a projective task will be stilted, repetitive, focused on details and slowed due to perfectionism. Whereas the young adult with psychosis may verbally talk about obsessions, s/he will perform without any of these behavioral features. As with all observations of performance, these can significantly add to understanding, therapeutic dialogue, choosing further evaluations, and intervention planning.

The second layer is at the level of the content of the productions, and the non-verbal communication these activate. While not one expert advocated the use of a symbolic equivalencies for interpretation, most described a client's projective productions as their own *"finger print",* identifiable amongst all others once seen. The themes and evocations of the creations afford an emotional, embodied, alternative way of 'knowing' (or empathically understanding) a client's experiences in their body and world(s) (Butler-Kisber, 2008). So, while two clients may both be able to say 'I no longer feel like myself', a well-executed centered drawing of a dislocated face floating in a spider's web elicits a different evocative response than the drawing of a tiny naked human figure drawn – speck like – in the bottom corner of a page. These differential depictions lead the occupational therapist to differing stories about what may be meaningful or at stake for a client, and his or her illness experience; as well as clues about his or her occupational identity and performance issues, and therefore what questions to ask about their challenges and recovery needs.

From policy guidelines for recovery oriented care (Mental Health Commission of Canada, 2012), and in line with client-centered practice (Sumsion, 2005), it is recommended that the clinical interpretations of a projective evaluation be reviewed and discussed with the client in a subsequent session without the use of jargon or professional terminology. That is, following the intimate sharing which can occur during a projective evaluation, the occupational therapist could schedule a follow up appointment to (1) allow the client time to reflect and return with further clarifications or queries (2) share with the client the projective interpretations and perceived issues with occupational functioning or occupational identity challenges, and verify if this is concordant with the client's understanding of their situation in order to (3) generate a collaborative problem list or goals, further evaluations, and intervention details.

This type of post assessment review process has been described in the Facts of Environmental Life (FEL) projective assessment (Farnham & Chase, 1982). The post-projective assessment discussion is included as part of the evaluation as a whole. This begins with giving the client time to reflect on his or her experience of the projective evaluation, and what has been created. For some clients this may occur immediately following completion of the expressive assessment while for others it would be judicious to re-

schedule a second session during which the productions are re-visited and discussed. The occupational therapist would ask questions such as "what strikes you about what you have shared and created? Do you see any recurrent themes? Which of these do you feel is most important to you?" This type of extension to the projective assessment fosters a client-centered collaborative approach that allows a person to highlight what was most significant to her or him and how to interpret any patterns or salient aspects within the process, or any questions that were raised for him or her. The occupational therapist can transparently share a summary of what s/he has observed and understood to matter most to the client, while explicitly maintaining a power-sharing approach to negotiating meaning (Sumsion & Law, 2006). For example, the occupational therapist can invite the client to disagree with the offered interpretations.

This reflective dialogue would include the problems and strengths that the client has identified during the evaluation and those that the occupational therapist has observed. It is important to note that, in this first post-assessment discussion, one needs to consider the client's level of comfort, awareness and acceptance. In fact, this type of follow-up session offers a further evaluation of the client's readiness and ability to engage in a process of change without adverse reactions, such as an intensification of depressive guilt, psychosis, anxiety or suicidality. Thus, it is necessary to follow the client's tempo and if needed, gradually bring up and address further exploration of meaning and challenging issues in subsequent therapy sessions.

Such an approach to framing occupational therapy projective evaluations as a whole therapeutic process intends to level out the power dynamics (Slade, 2009), verify and renegotiate interpretations, and begin a collaborative intervention process. The projective evaluation session begins with a creative, open-ended expressive projective assessment that is conducted side-by-side rather than in an expert-patient approach, followed by a collaborative approach to creating understanding and meaning. This is in line with a recovery philosophy of mental health care (Deegan, 2005; Thornton & Lucas, 2011).

Thus, we propose that expressive assessments can be conceptualized and developed as both a basic skill and a specialty process of evaluation in occupational therapy. This argument is analogous to evaluating driving ability or dysphagia: Such evaluations are only used when clinically indicated, all occupational therapists should be able to screen for driving or swallowing difficulties, yet further in-depth evaluations require certification or additional education. Consequently, projective evaluations should be maintained in curricula as part of the occupational therapist's basic toolkit in psychosocial practice.

Projective assessments can be used by occupational therapists with clients three years and older, who can narrate a story in relation to their productions, and who have the physical ability to manipulate the offered media. Clients can have either physical or psychiatric difficulties, and be seen in either institutional or community settings. Occupational therapy projective assessments can be used to evaluate the emotional and relational dimensions of occupational identity with any client experiencing complex psychosocial issues. The acceptability of an arts-based assessment process should guide the use of an expressive assessment with a given client. We recommend the use of such assessments in order to both refine mental health case

formulation in situations where history, presentation and/or ability to communicate are nebulous, as well as to initiate a safe experience of therapeutic rapport (see Table 6.2).

<Table 6.2>

For the sake of clarity, authentic clinical vignettes are provided from the first author's clinical practice to illustrate key points listed above. In the order presented, the first vignette highlights procedural-diagnostic reasoning and the detective genre, followed in the second vignette by a focus on narrative-interpretive reasoning for meaningful journeying and healing.

A 40-year-old Eastern European woman with no previous psychiatric history, and well functioning in her employment, experienced what appeared to be a first psychotic episode. She was accepted to a tertiary care specialized early intervention program, started on anti-psychotic medications and referred to occupational therapy for return to work issues. In the first interview, she was unable to narrate a chronologically coherent or seemingly reliable story. Given the communication difficulties, an Azima Battery was administered (Cramer-Azima, 1982). No organizational or perceptual issues were present, but what were noted were stark differences in the treatment of the male and female human figure drawings. The occupational therapist inquired about relational-sexual, body image, or intimacy issues in informal language such as "would you mind sharing a story about your intimate relationships" and "what do you see when you look in the mirror?" With great shame and hesitation, and after much roundabout questioning, the client eventually revealed a long-standing history of dissatisfaction with her body image, and repeated use of extreme dieting measures. The occupational therapist suggested that the client bring her diet pills to her next medical appointment. Upon examination, the psychiatrist concluded that the client was experiencing a caffeine-induced psychosis from an excess of over-the-counter natural products. She was asked to stop using these diet pills. She stabilized within two weeks and was discharged from the specialized early intervention program to a community therapist, with no psychiatric medications prescribed or required.

A 16-year-old Inuit boy was brought into an adolescent milieu therapy unit for a severe suicide attempt. He presented as electively mute and unable to tolerate the confined inpatient setting or individual verbal sessions without becoming highly agitated. He would attend occupational therapy groups but it was very difficult to find a meaningful activity with which he would engage. He would sit quietly in groups, profoundly withdrawn. A House- Tree Person Projective Drawing Technique (Buck, 1970) was qualitatively administered to aid in engagement and treatment planning. He drew an

igloo for a house, an arctic shrub for a tree, and for the person he drew an Inukshuk (a rock-based formation typically built by Arctic communities as geographical signposts). All objects were small and faintly drawn in desolate landscapes, floating high on the page without ground lines. As interviewing gently proceeded, allowing the client to lead the topics of the associations, he began to narrate that the Inukshuk was not a person, but was drawn to show him the way because he was 'lost'. He was then able to relate that the key men in his life (his father, uncle, older brother and best friend) had all become 'lost' and had committed suicide. When asked if the Inukshuk were a person, who might it be? He said it might be his older sister who could show him his way home, as she takes care of the family and 'knows the way she must walk'. Upon further exploration, he said his sister was proficient at leather handiwork, so following the evaluation, this activity was offered to him in an occupational therapy group with ensuing engagement and rapid positive results: He began to make connections to the other group members, and sewed a pair of leather gloves to bring home to his sister.

6.6.2. A conceptual orientation for developing clinical competence

The occupational therapist student or clinician interested in developing practical know-how in the use of occupational therapy projective assessments with clients is encouraged to learn about projective theories and available empirical studies. The reference lists of Parts I and II of this paper are intentionally comprehensive, and are offered as a reading resources. Developing exploratory interviewing skills aimed at eliciting lived experience such as in narrative interviewing in occupational therapy (Helfrich, Kielhofner, & Mattingly, 1994), qualitative research (Davidson, 2003a; Mattingly & Lawlor, 2000), or in health care in general (Groleau, Young, & Kirmayer, 2006), is a necessary step.

In addition, it is important to expand one's knowledge of theories and philosophies that focus on eliciting and interpreting stories and subjectivity within a relational process. Beyond traditional models of psychotherapy, the occupational therapist has the choice of diving into any of the following theories for practice: object-relations theories developed in occupational therapy (Eklund, 2000, 2002; Nicholls, Cunningham Piergrossi, de Sena Gibertoni, & Daniel, 2013), expressive and creativity frameworks (Frye, 1990), or phenomenological traditions in occupational therapy or psychiatry (Park Lala & Kinsella, 2011b; Reed, 2011; Stanghellini, 2011). Any of these would need to be married to, or contextualized by, an arts approach to activity analysis (Kossak, 2009; Perruzza & Kinsella, 2010). The choice of a primary theoretical model would be dependent on the psychosocial needs of the targeted clientele, the occupational therapist's educational preparation, and available mentoring.

This theoretical material would be iteratively combined with practice-based learning and supervision, using a variety of strategies. Ideally, occupational therapy curricula would expose the student to projective theory, current research on projective assessments, modeling of projective interviewing with clinical faculty or

through the use of teaching videos, and practical non-client simulated clinical assessment experiences. Applied clinical reasoning seminars would help the occupational therapy student to develop interviewer, analyzer and interpreter skills. The curricula could include assignments in which the student administers and conducts an in-depth analysis of the productions of an expressive assessment, which would help to consolidate theory and practice. Further, students could be encouraged to experience a 'real' clinical projective assessment during a clinical placement.

A conceptual depiction, emerging from the first author's doctoral work in this area is offered (see Figure 6.1). The figure intends to convey the necessary elements for conducting and analyzing a client-centered projective evaluation. It requires the development of interviewing skills and a therapeutic use of self and self-awareness; a working knowledge of projective theories; observational and interpretive skills in the analysis of expressive activity performance; and an emphasis on narrative reasoning skills (Mattingly, 1991a, 1998b). Finally, it is recommended that the occupational therapist ensure a recovery-oriented attitude, as articulated in international policy that places primacy on the first-person perspective of a client's biography and experiences (World Health Organization, 2012).

Figure 6.1 also outlines suggested avenues for research. It would be ideal if clinicians and students who embark on the use of projective assessments find ways of partnering with other researchers. Alternatively, as more occupational therapists become clinically licensed at the graduate level, it is hoped that generating knowledge on projective evaluations in tandem with advanced clinical work will be facilitated.

<*Figure 6.1.*>

6.6.3. Research Avenues

In spite of a history that spans over six decades, the domain of projective assessments in occupational therapy is indeed "a field which is in the very early stages of scientific research" (Lloyd & Papas, 1999, p. 33). The comprehensive and critical review provided in this two-part article suggests specific research avenues rather than broad sweeping statements about 'where to next' in the clinical development of occupational therapy projective assessments (Appendix 9). The concept map is provided herein as a place to begin. Clearly, as knowledge expands in this area, revisions will need to be made to the research questions and designs, in a phasic and 'recursive' approach to inquiry (Christ, 2007).

In terms of which specific occupational therapy projective assessments to study, choices need to be based on historical development-for-use, targeted client group, and existing evidence. For example, the Azima Battery was developed specifically for use with a clientele experiencing psychosis to elicit communication and psychodynamic diagnosis (Azima & Azima, 1959), whereas the Magazine Picture Collage was designed to evaluate "core aspects of personality organization" with a broader clientele seen in psychiatry (Lerner, 1982, p. 140). One might consider the development of new occupational therapy projective assessments; however, these take years to develop and to research their validity. Given that expressive projective assessments already exist and are being used clinically in occupational therapy, it might be more expedient to focus research on

these assessments. Further, we now have appropriate research tools e.g. qualitative methodologies and statistical means to do so. The future development of new expressive assessments for specific client groups would need to take into account the contemporary relevance of particular media, and of research findings about the specific expressive utility of a chosen arts-based activity.

In making these choices, the first question for an invested occupational therapy community of practice to clarify is the actual purpose of the projective assessment that is to be studied. While clarity about the multiple agendas and uses of projective assessments has been provided in this article, it would be important to engage in an occupation-centered dialogue. The use of projective assessments in mental health must also consider the changing aspects of psychiatric practice, and be articulated within a shifting paradigm that places primacy on lived experience, voice and empowerment, and the social determinants of health (Kirby & Keon, 2006).

There are many conflicting issues around the question of projective assessments as a tool to aid in the diagnosis of psychiatric pathology, as well as ongoing debates about the nature of mental illness and the instruments' cross-cultural validity. Thus, it behooves occupational therapists who use and study projective assessments as diagnostic aids to remain abreast of the debates. If a true biopsychosocial conceptualization to mental illness is maintained, regardless of whether a mental illness is a disorder of the sense of self in relationships (Lysaker & Lysaker, 2005; Sass & Parnas, 2001), or a series of reducible discrete biological diseases, projective assessments can certainly aid in interdisciplinary dynamic case formulation of mental health status, as originally advocated for in psychiatric occupational therapy (Fidler & Fidler, 1954). In addition, a client's phenomenological expression of living with mental health issues within the particularities of their psycho-social-cultural history and situation can be therapeutically elicited and understood in an expressive evaluation process. In line with new mental health policies and ensuing legislature, such as Bill 21 in Quebec (Office of Professional Orders in Quebec, 2013), all mental health professionals are being called upon to aid in the diagnosis of mental health issues. This requires the validation of assessments that purport to fulfill this task through the use of rigorous quantitative designs (e.g. Li et al., 2011). Further, from an occupational perspective, one might consider a research design to validate the use of projective assessments as an evaluation of emotional and relational functioning, and correlate projective clinical impressions with appropriate measures of occupational functioning (e.g. Chen-Sea, 2000).

If one of the primary clinical purposes of a projective assessment is therapeutic rapport and understanding, then which scientific methods are best suited to studying projective assessments? The relative lack of research evidence echoes this statement from decades ago: "Most early workers…were more concerned with coherencies meaningful in understanding the persons with whom they dealt than with the requirements of objectivity and verifiability that preoccupy the scientist" (MacFarlane & Tuddenham, 1951, p. 27). This explains the predominance of case reports and clinical descriptions and inferences in the early literature. In the present day, examples of solid quantitative studies are available (Chen-Sea, 2000; Li et al., 2011). Yet these designs would not further the aim of meaningful understanding.

Qualitative research is the best approach to understanding processes and reasoning. Currently in the domain of projective assessments in occupational therapy, however, the use of contemporary rigorous approaches to qualitative and mixed methods designs are uncommon. It was almost six decades ago that MacFarlane and Tuddenham advocated for research to explore the clinical reality of the "interpreter-with-his-test" (1951, p. 51) to explicate the intersubjective processes that projective evaluations disclose. This article proposes that this cannot be done through further refinement of quantitative methods. Quantitative experimental designs "…[do] violence to the actual clinical use of such signs" (Hammer, 1981, p. 177). There is an imperative need to meet the call of occupational therapists who use projective evaluations for both interpretive case formulation and as a meaning-making and sharing activity to shift into qualitative or mixed methodology research that is consistent with the theoretical underpinnings and clinical use of expressive projective evaluations.

Qualitative research designs are being advocated as particularly suited to research in occupational therapy on clinical reasoning, capturing the 'hard to measure' in therapeutic processes and actual outcomes. Qualitative research designs are also consistent with the values and clinical use of therapeutic models of assessment (Cook, 2001; Miller & Crabtree, 2005; Papadimitriou, Magasi, & Frank, 2012). The values that underwrite interpretive qualitative approaches mesh well with the shift in theoretical orientation in psychiatry towards the first-person perspective and the creation of personal meaning in recovery and community-based psychiatry (Davidson, 2003a).

For example, in line with the client-centered expressive potential of projective assessments, a research design where clients are interviewed about the perceived benefits of projective assessments and techniques could be conducted. Some preliminary data is available about the therapeutic value occupational therapy clients place on projective assessments (Gunnarsson, Peterson, Leufstadius, Jansson, & Eklund, 2010; Han Men, 2004; Wittkower & Azima, 1958). It would be interesting not to limit such research to clients in mental health but to also maintain openness to the use of projective evaluations in physical rehabilitation settings for clients with psychosocial dysfunction (Ikiugu, 2010).

Qualitative research can continue laying the groundwork for the further development of occupational therapy clinical guidelines for the use of expressive assessments. Therefore, a next logical step would be to extend the narrative study of expert opinions reported herein, by enlarging the sampling process and criteria to achieve theoretical saturation. This would lead to the rigorous development of expert-based clinical guidelines. In tandem with client perspectives, such guidelines would inform both clinical practice as well as research questions.

Another qualitative research aim would be to develop an occupational therapy-specific interpretive framework for analyzing projective assessments. This may be a strategic component for the refinement of competency and learning in this area as well as the ongoing validation of their clinical use. Grounded Theory (Glaser & Strauss, 1967) is a qualitative research approach which develops theories or conceptual maps of processes, such as expert clinical reasoning, in order to develop a conceptual framework from the ground up

(e.g. Edwards, Jones, Carr, Braunack-Mayer, & Jensen, 2004). Therefore, qualitative study designs that explore *in-vivo* case-based expert clinical reasoning using grounded theory could be suggested for research on expressive assessments.

Another way of exploring the intersubjective unfolding and observed performance of a clinical projective evaluation session could be with the use of a video-based design coupled with a phenomenological analysis. The term phenomenology can refer to three different levels of meaning: a basic description of observable signs or 'phenomena', a description of subjective experience, and the attempt to grasp the essence of facets of human experience (Rulf, 2003). All three levels are important in order to meet the aims of phenomenological research to describe the structure and essence of lived and shared experience through expressive action, dialogue, and reflection (Patton, 1990; Rossman & Rallis, 1998). Phenomenological approaches ensure that "the experiencing intersubjective person is back at the center of the analysis" (Harland, 2007, p. 249). As argued above, phenomenology is a philosophical root for expressive assessments, and its application in research can provide the language and understanding to elucidate aspects of subjective experiences and their relationship to activity performance and mental health (Park Lala & Kinsella, 2011b; Park, 2012).

Finally, research on the clinical utility and validity of a particular projective assessment with a given clientele is best addressed using a mixed methods research design (Streiner & Norman, 2008). Mixing methods is an approach used in the development and refinement of instruments, where the "results from one method [are used] to develop or inform the other method" (Hanson et al., 2005, p. 226). This involves the use of both quantitative and qualitative data collection and analysis. For example, the use of quantitative objective measures of patterns of occupational performance on specific tasks of an expressive projective assessment that are statistically correlated with the diagnostic impressions generated by that projective assessment can be examined in tandem with a qualitative analysis of the clinical reasoning which leads to the diagnostic impression in the projective profile. "A major advantage of mixed methods research is that it enables the researcher to simultaneously ask confirmatory and exploratory questions … in the same study" (Teddlie & Tashakkori, 2009, p. 33). Mixed methods can follow a pragmatist approach to knowledge generation (Morgan, 2007), which means that research results are evaluated in terms of their utility and practical consequences in real settings. This type of research has been said to be a significant methodology for occupational therapy (Duncan & Nicol, 2004).

Alongside Polatajko & Kaiserman, rather than admitting to "the difficulty in establishing rigorous evidence" for projective assessments (1986, p. 198), this article visualizes the numerous research possibilities from qualitative and mixed methods perspectives. These methodologies are now well known and their use continues to rise in health care as well as in occupational therapy.

6.7. Conclusion: Ways of telling, ways of knowing

In this two-part article, a comprehensive review of the scientific literature and expert opinions has been provided in a historically situated manner. The core ways of thinking about occupational therapy projective assessments have been reframed and updated. The purpose here was to articulate the pertinent clinical, theoretical and research issues in order to better support the clinical use of projective assessments. Striving for clarity herein is intended to encourage occupational therapists interested in this field to keep engaging in both a productive dialogue and legitimate development of a domain of practice that continues to hold clinical value.

Projective assessments offer an occupational therapy specific approach to (i) evaluate relational and activity performance difficulties; (ii) contribute to mental health case formulation; and (iii) provide a recovery-oriented form of evaluation which is engaging and elicits an individual's personal biography and shared meaning. Projective assessments have a well-established clinical history in psychosocial occupational therapy. This has not been matched by a critical development of a solid research base or refinement of their conceptual foundations. The timing is once again appropriate to re-visit expressive assessments as the pendulum in mental health is swinging past biological psychiatry towards social inclusion, recovery and the return to subjectivity and lived experience. Thus, occupational therapy curricula should retain or include the theory and practice of using expressive projective techniques for assessment and therapeutic purposes. Simultaneously, occupational therapy research has expanded in methodology and sophistication in order to develop the scientific knowledge base for the clinical utility and validity of expressive assessments.

The psychosocial roots of occupational therapy are being called upon to promote the clinical and research practices of occupational therapists (Hammell, 2007, 2013). Elaborated within this tradition, projective evaluations afford clients a different way of telling, relating, revealing, and performing their occupational identity and experiences, and they afford occupational therapists a creative way of knowing and understanding their clients.

6.8. Acknowledgments: The late Dr. Fern Cramer-Azima was Associate Professor of Psychiatry at McGill University. She was in her mid-80's at the time of data collection and she graciously welcomed the first author into her home for a whole afternoon in spite of medical frailties. Her passion and commitment to youth mental health was evident in her level of engagement in the interview, and her transdisciplinary grasp of the notion of "projection" was an inspiration. She spoke of the development of the Azima Battery with enthusiasm and clarity, and she stated her ongoing belief in the centrality and necessity of occupational therapy's focus on 'doing' in mental health. Although he had been gone for many years, her partner in both personal and professional life remained her husband, with whom she had co-created the Azima Battery. She passed away on December 18th, 2013.

The following professionals are thanked for taking the time to share their expertise: Ms. Andrea Blanar, MA. Fine Arts and occupational therapist, Institute of Community and Family Psychiatry, Jewish General Hospital; Ms. Sonia Geller, occupational therapist and former occupational therapy team leader and clinical administrator of the anxiety program, McGill University Health Centre; Ms. Beverley Stacey, MA. Creative Arts Therapies, retired occupational therapist, adolescent and adult inpatient psychiatry, McGill University Health Centre; and the five other generous occupational therapy experts who chose to remain anonymous.

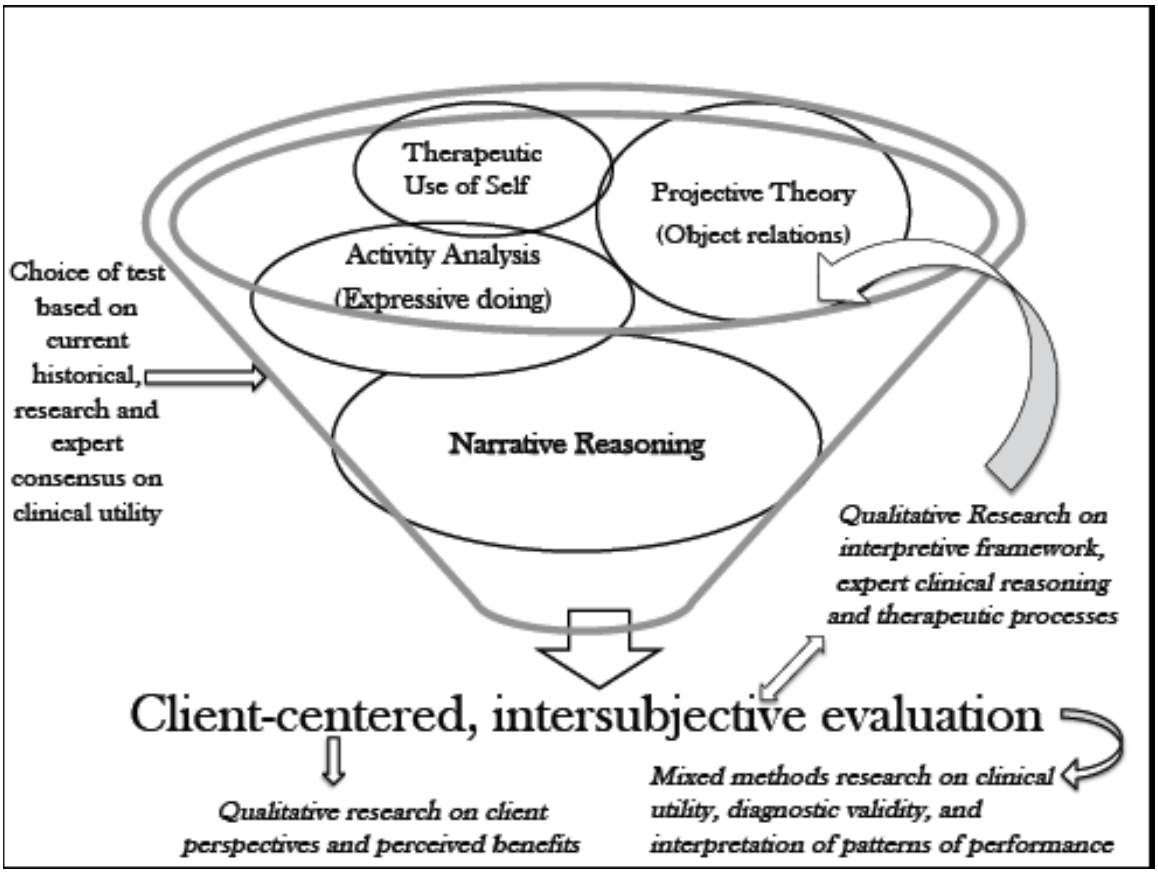
TABLE 6.1: INTERVIEW GUIDE

Why use projective assessments in occupational therapy?
How has your use of projective assessments evolved over time?
With which clients would you use a projective assessment?
How do you interpret the media and session?
What kind of educational preparation would you recommend for clinicians?
Why continue using occupational therapy projective assessments?

TABLE 6.2: GUIDELINES FOR THE CLINICAL USE OF OCCUPATIONAL THERAPY PROJECTIVE ASSESSMENTS

Case formulation	When psychosocial case formulation is vague with a client presenting with complex psychosocial problems When any of the following are suspected in the occupational history or rehabilitation process, but cannot be confirmed by more direct methods: psychosis, suicidal ideation or intent, harm to others, undisclosed history of trauma, organic brain disease such as dementia, depression, self-harm, or dissociation When any of the following are part of the clinical presentation in mental health: Long history of psychosocial difficulties without overt symptoms Child, adolescent, and young adult developmental phase problems Adult with no previous difficulties whatsoever When socio-verbal performance strongly contradicts the occupational history and current interpersonal behavior and occupational functioning When initial evidence-based psychosocial interventions have failed
Expressive opportunity for client-centered understanding & therapeutic rapport	When the client is highly verbal and uses words to disguise feelings and/or to confuse the therapist, such as intelligent individuals with mild-moderate depressive disorders. Since these assessments require the production of objects, the client is less able to obfuscate in expressive actions (Anastasi, 1982, pp. 580-589) When establishing rapport and communication in an exclusively verbal mode is a challenge, and finding a meaningful activity is not forthcoming, or when the client has difficulty with self-expression, communication, reflection, and/or interpersonal connectedness due to illness, and/or sociocultural situation
Change detection & documentation	Since there is a lack of a set response pattern, a projective assessment can be re-used to monitor for change (Azima & Azima, 1959) A projective assessment can be used as a well thought out outcome measure. For example, changes in body image after sensory integration interventions (Levine et al., 1977)

FIGURE 6.1: CONCEPT MAP FOR OCCUPATIONAL THERAPY PROJECTIVE ASSESSMENTS



Linking Statement

The comprehensive review situating the utility of occupational therapy projective assessments supported the relevance of the use of arts-based evaluations with adolescents and young adults for various reasons. These included the acceptability of such assessment types with individuals whose creativity maybe less inhibited than adults, the unthreatening nature of a side-by-side approach that fosters communication at the client's pace, and providing the adolescent or young adult with a vehicle for expression when verbalizing experience may be compromised by illness, developmental phase, resistance to the patient role or other psychosocial effects.

The review also clarified the tensions between the diagnostic and therapeutic functions of expressive assessments, while providing expert consensus for both clinical uses. The following manuscript examines the diagnostic function of the first published Canadian occupational therapy projective assessment – the Azima Battery – that was designed for use with individuals experiencing psychosis and schizophrenia. Specifically, the study evaluates the predictive ability of the Azima Battery in detecting schizophrenia prior to full-blown onset, in a sample of youth seeking help from early psychosis services. The potential of the Azima Battery in detecting incipient schizophrenia is postulated based on clinical and empirical understanding since 1926 that "…pathological art may occur prior to the onset of illness, indicating its value as a prognostic sign" (Amos, 1982, p. 136).

The following study addresses a gap in the occupational therapy literature by using a modern scientific approach to assessment validation, while also maintaining fidelity to the phenomenological tradition of projective assessments developed within occupational therapy. This is done through the use of a mixed methods phenomenological research design whose sample size for quantitative analyses matches that of other studies examining early detection in psychosis. In complement, the qualitative component focuses on the occupational therapy particularity of observing and analyzing expressive activity performance through a phenomenological (descriptive) lens.

Chapter Seven (manuscript)

Detecting incipient schizophrenia: Validation of the Azima Battery in First Episode Psychosis

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Formatted for submission to *Psychiatric Quarterly*

7.1. Abstract

Background Early psychosis intervention aims to accurately detect adolescents and young adults at risk for major mental disorders, yet biomedical diagnostic accuracy in the early phases of illness remains poor. Phenomenological approaches to diagnosis demonstrate greater ability in detecting incipient schizophrenia. **Purpose** To estimate the predictive validity of an occupational therapy projective assessment, the Azima Battery, with youth seeking help for a first episode of psychosis, and identify patterns of performance distinctive for a diagnosis of schizophrenia 1-year later. **Methods** A mixed methods phenomenological approach was used to calculate predictive validity and qualitatively identify patterns of performance. **Findings** Diagnostic accuracy of the Azima Battery is greater than psychiatric interviewing for a future diagnosis of schizophrenia (n=62: 88.7% vs 42%). Performance elements distinctive of schizophrenia relate to the structure of created objects. **Implications** The Azima Battery is a valid measure for clinical use by occupational therapists working in early intervention for psychosis.

Keywords

Phenomenological mixed methods research, First Episode Psychosis, Projective Assessment, Predictive Validity, Activity Performance

7.2. Introduction

Severe mental illness often strikes in youth, with 70% of disorders beginning in adolescence and young adulthood. Further, the largest percentage of first time youth psychiatric hospitalizations is for schizophrenia (Canadian Institute for Health Information, 2011). In Canada, psychosis is the 12th cause of disability (Mitchell, 2004); however, the burden of psychotic-spectrum disorders in youth is estimated as the third most disabling condition worldwide (World Health Organization, 2001). Beginning with the impetus to prevent the psychosocial disabilities associated with schizophrenia (Bertolote & McGorry, 2005), early intervention in psychosis has become a mainstay for youth mental health across the globe. In Canada, all provinces have adopted guidelines for best interdisciplinary intake and evaluation practices that focus on both therapeutic rapport and accurate assessment with youth seeking help for a first episode of psychosis (FEP) (Ehmann et al., 2010; Ministère de la Santé et des Services Sociaux, 2005).

In the absence of true pathophysiological markers of disease, accurate assessment and diagnosis in the early phases of mental illness is tenuous and physicians must "remain prepared to revise the provisional diagnosis" (Mental Health Evaluation & Community Consultation Unit, 2000, p. 4). The validity of an initial psychiatric diagnosis is weighed against longitudinal diagnostic stability, which involves monitoring how unchanging an initial diagnosis is in subsequent evaluations (Chang, Chan, et al., 2009). Diagnostic stability is usually achieved within 12-18 months for the early psychosis clientele.

Studies with adolescents and young adults presenting with (pre)psychotic symptoms or a true FEP demonstrate that the diagnostic accuracy of the initial diagnosis hovers between 34-68% at 1 and 2 year follow-up (Addington, Chaves, & Addington, 2006; Fraguas et al., 2007; Rahm & Cullberg, 2007). For those who are given an initial diagnosis of schizophrenia, prospective consistency is greater than 95% (Chang, Pang, Chung, & Chan, 2009). However, studies demonstrate that 20-50% of initial diagnoses are changed within the first year, with the majority conversion being towards a diagnosis of schizophrenia (Holtzman et al., 2010; Kim et al., 2011). When diagnosed, specificity for an initial diagnosis of schizophrenia can be quite high; however, sensitivity of initial diagnoses with the clinical use of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is less than 60% (Amin et al., 1999). A systematic review of diagnostic stability for individuals with first-onset psychosis concluded that the uncertainty and instability of initial diagnosis is to be expected in the early phases of psychosis, and is only resolved with longitudinal monitoring (Chang, Chan, et al., 2009). Therefore, when a diagnosis of schizophrenia is made, it does remain stable across time; however, the accurate initial diagnosis of incipient – or emerging - schizophrenia is low in practice, in spite of a 50-60% prevalence of the disorder within the FEP population (Ramirez et al., 2010).

Reasons for these diagnostic statistics likely include differential gender and cultural presentations of schizophrenia that may not be taken into account during the diagnostic process (Holtzman et al., 2010; Zandi, Havenaar, Laan, Kahn, & van den Brink, 2011). For example, women tend to have a later age of onset, improved social functioning and better remission rates leading to greater difficulties in detection (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). Culture also influences help-seeking behavior as well as the

experience and expression of symptoms, thus impacting detection (Corin, Thara, & Padmavati, 2005). Further, the early intervention paradigm is to initially consider 'an episode of psychosis', rather than a chronic mental illness, in order to promote hope (Bertolote & McGorry, 2005). This may lead to reluctance in diagnosing schizophrenia.

In addition to these complex sociocultural effects, critics have also highlighted that the underlying categorical approach to psychiatric diagnosis in North America is itself potentially flawed, and that an epistemological shift to a phenomenological approach to detecting and understanding schizophrenia is needed (Parnas, 2011). Phenomenological psychopathology aims to understand the expression and structure of the whole pattern of the individual's experience, in order to explicate the individual's diagnosis (Stanghellini, 2007). This form of interviewing has been demonstrated to be more predictive (> 70%) of the onset and long-term diagnosis of schizophrenia (Klosterkötter et al., 2001; Raballo & Parnas, 2012).

Occupational therapists can use projective assessments within a phenomenological frame in order to establish therapeutic rapport and collaboratively conceptualize a client's mental health issues (Reynolds, 2008). There is evidence for the validity of associative projective assessments, which rely on verbal responses, in diagnosing and distinguishing psychotic-spectrum disorders from other psychiatric disorders (Burton & Sjoberg, 1964; Heidgerd, 1958/1980; Lilienfeld et al., 2000). Occupational therapists use expressive projective assessments that rely on the use of unstructured art media to tap into the layers of an individual's experience as projected or expressed in the process of creation, as well as the verbal narratives about the created objects. This approach to evaluation is particularly useful with adolescents and young adults (Zafran & Tallant, 2015b). The significant distinctive element of occupational therapy projective assessments is the combination of (1) facilitation of communication and sharing between the occupational therapist and the participant about the latter's experience through the expressive use of art media, in a side-by-side unthreatening manner (Thompson & Blair, 1998); and (2) provision of the opportunity to observe an individual's ability to engage in activity performance of an unstructured and expressive nature, and thus has the potential to identify activity performance deficits that precede the onset of a full blown psychiatric disorder (Woodside et al., 2007).

The Azima Battery is the first activity-based assessment with a standard set-up published in Canadian occupational therapy (Zafran & Tallant, 2015a). It is the only projective assessment within occupational therapy specifically designed to aid in communication with, and diagnosis of, persons with schizophrenia-spectrum disorders (Azima & Azima, 1959). It is also the only one explicitly conceptualized in line with phenomenological principles for interviewing and case formulation (Cramer-Azima, 1982). The Azima Battery is a projective assessment that relies on the use of art media combined with open-ended interviewing. It involves a standard setup, sequence, and opening instructions whereby the client is asked to create five objects in three media: three pencil drawings of anything, a person and a person of the opposite sex; a clay object and a finger-painting. The sequence of tasks moves from more familiar media (paper-pencil) with direct instructions about what to draw, towards more expressive tactile media (clay and fingerpaint). Each task is followed by a period of open-ended association and collaborative exploration of the created objects in

relation to the individual's projected meaning and experiences.

As part of a broader research project exploring the contemporary clinical utility of the Azima Battery, this study sought to examine the validity of the diagnostic impression generated by the Azima Battery in predicting diagnosis in adolescents and young adults presenting to FEP services, at one year later in comparison to the predictive validity of the initial diagnosis posed by the attending psychiatrist (i.e. a comparison to current practice). The second aim of this study was to identify patterns of activity performance distinctive of a future diagnosis of schizophrenia in this population.

7.3. Methods

7.3.1. Setting

Data collection was conducted within a Canadian urban university teaching hospital that had created the first early intervention services for psychosis in that city in 1997. The study included retrospective and prospective data collection from help-seeking patients receiving services for a FEP. Ethical approval was received from the institutional review board of the hospital where the study was conducted.

7.3.2. Sample

The study focused on help-seeking individuals 14-30 years of age receiving early psychosis services for less than 3 months. Inclusion criteria included participants who met the Melbourne criteria for risk of psychosis (Parker & Lewis, 2006), or were experiencing their first episode of psychosis. That is, they might have been experiencing (i) prepsychotic or brief or intermittent psychotic symptoms, or (ii) confirmed first-time transition into psychosis, or (iii) have a decline in psychosocial functioning while also having relatives diagnosed with a psychotic-spectrum disorder (McGorry et al., 2003). Exclusion criteria included psychotic features secondary to an identified neurological cause (e.g. epilepsy).

7.3.3. Measures

Azima Battery

The Azima Battery is composed of five tasks in three media and has a standard set-up, sequence, and opening instructions for the tasks (Azima & Azima, 1959). The interviewer and participant sit side-by-side at a table (rather than face-to-face). In front of the interviewer are pencils, an eraser, paper sheets for drawing and finger paint (12"-18"). Lined at the top of the table are bottles of finger paint in six set colors, a sponge and bowl of water, and a three lb. ball of red clay (see Figure 4.1). Following an introduction to the evaluation that focuses on art media as a means of communication rather than artistic ability, the interviewer hands a drawing paper, pencil and an eraser to the participant and asks them to 'draw anything that comes to your mind'. The following tasks require the participant to draw a person, then to draw a person of the opposite sex. This is followed by the more expressive, or tactile, tasks. After the drawings the participant is

offered a 3 lb. ball of clay out of which they can make any object of their choice, and finally, to create a finger-painting.

This is a general structure within which there is flexibility for exploratory, phenomenological questioning that follows the participant's lead (Cramer-Azima, 1982). Participants are told that they have no time limit for their creations, and unless they initiate conversation, this occurs in silence with quiet observation and verbatim note-taking by the interviewer. Following each task an open-ended period of interviewing begins with 'tell me about what you have made'. The open-ended phenomenological interviewing focuses on the experiences elicited by the process of creation, the meaning attributed to the object, and safely exploring the associated experiences and memories that emerge. Clinical analysis of the individual's projective profile is summarized within a projective report, which includes a case formulation of the primary mental health issues, and recommendations for clinical care.

Demographic Characteristics

In addition to the data from the Azima Battery evaluation session, the following data were extracted from the medical records and occupational therapy charts of all subjects: Date of birth, age at first contact with psychiatric services, socioeconomic and occupational status, and educational history upon referral were all noted in either interval or ordinal format. In addition, variables known from the early intervention literature to be linked to the risk of developing psychosis were also extracted from the medical chart and documented using a Likert scale. These included family psychiatric history, reported adverse life events from childhood onwards, substance use, and immigrant status. The exact dates and service settings (early psychosis intervention, day hospital, inpatient unit) of the initial diagnostic interview and the Azima Battery evaluation were also recorded.

Psychiatric diagnosis

The initial diagnostic category posited by the treating psychiatrist within the same service setting and time period of referral to occupational therapy for evaluation was ascertained form the medical chart and coded on a nominal scale using the categories of the DSM-IV TR (American Psychiatric Association, 2000). That is, the medical chart was searched to find the notes by the attending psychiatrist at the same identified date and service of the Azima Battery session, and the diagnostic impression that was entered at that time. If several chart notes were present, these were read to ascertain the psychiatrist's global impression, and the overall diagnosis posed by the psychiatrist was retained. The DSM-IV TR categories were assigned nominal values (1 for Schizophrenia, 2 for Psychosis NOS/NYD, 3 for depression, 4 for psychological trauma, etc.…). Each subject received one nominal value for diagnosis at intake into psychiatric services.

The most recent, final, or stabilized diagnosis was obtained form the medical chart for as close to 1-year follow up as possible and coded on the same nominal scale. The treating psychiatrists were consulted to confirm their initial and final diagnostic impression, as needed. The final diagnosis, recorded by a psychiatrist, was based on longitudinal clinical monitoring and ongoing interdisciplinary evaluations following entry into services. This final diagnosis was the outcome variable for predictive validation in this study.

7.3.4. Procedures

Two separate procedures were used for data collection in this study. Procedure 1: Between 2011-2013, individuals, speaking either English or French, and newly admitted to early psychosis intervention services were prospectively identified by treating psychiatrists and invited to participate in the study. Individuals were referred to the research without any diagnostic or biographical details, thus ensuring that the occupational therapy evaluator was not biased. They (n=9) completed a consent form agreeing to participate in a videotaped Azima Battery evaluation session with the first author. Procedure 2: Upon completion of Procedure 1, retrospective data collection took place over the summer of 2013. Diagnostic and demographic data were identified and retrieved retrospectively from the medical records of other individuals who had been accepted and/or referred to the early psychosis intervention services between 1997-2011 and who had also participated in an Azima Battery assessment in occupational therapy (n=53).

Data collection

All the occupational therapy evaluation sessions in both Procedure 1 and 2 were conducted by the primary author.

Procedure 1: For the nine participants who had engaged in the research evaluation session, the videotaped Azima Battery session, verbatim transcripts, all five created objects, and researcher's post-session reflective memos were included as data. The diagnostic impression described in the occupational therapy projective report was categorized on the same nominal scale as that of the psychiatrist's diagnosis. For the nine prospective participants, the occupational therapy evaluator was blinded to initial diagnosis upon their referral to the Azima Battery session. The projective analysis and report were completed by the first author within a week of the evaluation, and thus were also blinded to the final diagnostic outcome one year later.

Procedure 2: For the retrospectively identified sample, the objects created during the Azima Battery session were collected as data from the occupational therapy charts. This included the two-dimensional expressive materials (three drawings and one finger painting), the verbatim occupational therapy notes from the session, and final occupational therapy projective reports. For logistical reasons, clay productions were not available for the retrospective sample, thus, descriptions of sequence of performance and final clay product were taken from the original verbatim occupational therapy notes of the evaluation session, and the final report. For the retrospective sample, given that data was obtained from medical charts and routine clinical practice, blinding upon referral was not ensured. However, blinding to one-year diagnosis was obviously present.

7.3.5. Data Analysis

Estimation of predictive validity

Percentage diagnostic accuracy for the combined final sample (N=62) was calculated for both the initial psychiatric diagnosis at intake, and for the coded Azima Battery diagnostic impression, in relation to the long-term outcome diagnosis. The sample was then dichotomized into those with, and those without, a final

diagnosis on the schizophrenia-spectrum. Statistics for predictive validity were calculated for both the Azima Battery impression obtained from the projective report, and the psychiatrists' initial diagnosis at intake found in the medical records. Positive predictive values were calculated as the proportion of cases diagnosed with schizophrenia initially (according to the results of the Azima Battery and the psychiatrists' initial diagnosis) that were confirmed at one year. The negative predictive values were calculated as the proportion of all cases that were not diagnosed as schizophrenia initially that were truly a negative diagnosis at one year. Sensitivity was calculated as the percentage of individuals with confirmed schizophrenia who were accurately diagnosed initially. Specificity refers to the percentage of individuals identified as not having schizophrenia who were accurately detected by the initial assessment. These statistics were calculated for both the initial treating psychiatrist and the occupational therapist.

Mixed methods and patterns of performance

In order to meet the secondary aim of this study, a mixed methods phenomenological research approach was used to phenomenologically describe and then statistically examine the patterns of projective activity performance distinctive of early psychosis in individuals who develop schizophrenia. This type of mixed design is used when there is a need to begin with the qualitative identification of possible variables (Creswell, 2003, p. 228), such as patterns of performance. Data analysis was sequential-exploratory, beginning with the qualitative approach and moving into quantitative analysis.

Qualitative analysis

a) Phenomenological analysis: A descriptive phenomenological approach, in line with an objectivist quantitative epistemology was chosen to analyze the data obtained in Procedure 1. This form of qualitative analysis aims to describe the essential structure of a given phenomenon while bracketing out theory and other assumptions (Mayoh & Onwuegbuzie, 2013). In this study, the phenomenon in question was the potential pattern, or structure, of the experience of incipient schizophrenia as expressed in activity performance during the videotaped Azima Battery sessions (n=9). The aim was to describe each process and product of creation in such a way that if a third party were to read the description they would be able to reproduce the drawing, clay, or finger-paint with some measure of accuracy without having seen the original. This was achieved by bracketing out the researcher's assumptions of what the most salient features might be. This analysis involved immersion in viewing the videotaped sessions with and without the presence of sound, cultivating an open reflexive attitude by noting researcher assumptions and analyses in memos, and maintaining an open dialogue with a purposefully created reflection team (Finlay, 2008) involved in the data obtained in Procedure 1.

b) Reflective team analysis: Three occupational therapy experts participated in the reflection team. These included one expert in the realm of psychosocial occupational therapy, and two in measurement studies. The first expert participated in the observation and analyses of the videotapes (7 sessions; 28 hours), in order to generate themes describing the structure of activity performance. The two experts in measurement studies subsequently participated in questioning and refining the themes and their descriptors. The team contributed to the maintenance of an open-attitude, descriptive accountability, and rigor in qualitative

analysis. The emerging themes pertaining to the structure of activity performance were iteratively returned to and comparisons made between and across the nine participants.

c) Descriptive themes-as-variables: The finalized descriptive list of performance themes were treated as variables and transformed into categorical scales of either present (1)/ absent (0); or descriptive variations of low (1)-moderate (2) –high (3) for each of the five tasks, and for overall performance in the Azima Battery. All scales were coded so that higher numbers indicated higher risk, greater dysfunction, or predominant pathology. For example, from a phenomenological perspective, temporality is the subjective experience of lived time. The sense of time being static was structurally described in the following ways: (a) representations of human figure and/or animal objects as static or not moving, and/or (b) participant blocking or freezing in time during activity performance. This observed element was coded as an Action/Inaction item, and scored for each task as 0 if the figure or object was depicted in motion, or the process of creation was not halted. It was coded as 1 if the participant depicted static objects, or 'froze' during the process of creation. This codebook went through seven drafts with the reflection team. Once the codebook was finalized, no further changes were made and it was used to code the themes as variables for the activity performance and created objects for the whole combined sample from Procedures 1 and 2 (N=62) and entered into the statistical software SPSS (Levesque, 2007).

Quantitative analysis

Given that the objective was not to create a scale to score the Azima Battery, but rather to identify potential patterns, the variables thus created were treated as nominal. Phi & Cramer's V correlational statistics were conducted to identify the performance items significantly associated with a final diagnosis of schizophrenia. These significant performance items were concatenated within each task and treated as 'strings'. Concatenation is the operation of joining nominal (qualitative) information end-to-end. For example, if you have descriptors such as "poor=5" for performance item 1, "absent=0" for item 2, and "moderate=3" for item 3, these are strung together and are read by the statistical software as the string '5-0-3'.

In this study the strings were created out of the quantified nominal descriptors of patterns of performance that were significant within each task, so that each subject had their own string pattern for each task. The comparative frequency of each potential combination of these strings was calculated for those with, and those without, a final diagnosis of schizophrenia. This was to identify if certain patterns of performance items for each projective task were seen more frequently and/or exclusively for individuals with a confirmed diagnosis of schizophrenia.

7.4. Results

All individuals admitted to early psychosis services between 2011-2013 met the study criteria, of whom 12 agreed to be contacted by the researcher. Three individuals subsequently declined to participate, leaving nine individuals who participated in the videotaped evaluation sessions. Retrospectively, the medical charts of 64 individuals admitted for early psychosis services between 1997-2011 were identified as meeting

the inclusion criteria. Four charts were missing from medical records, three had significant follow up data missing, and four did not meet the criteria for the standard administration of the Azima Battery (e.g. did not complete the whole battery, or having a family member present during the evaluation session). Thus 53 medical charts were retained for retrospective data collection. Including the prospective sample of nine, a final total sample of 62 was achieved.

The demographic characteristics of the sample can be found in Table 7.1. The greater majority of the sample was male. Only 1/5th of the sample had been in Quebec for multiple generations, the remainder of the sample was either born in Canada and had moved to Quebec to attend university, or was a first or second generation migrant from another non-North American country to Quebec. Almost ¾ of the sample had experienced adverse life events at some point, including or overlapping with ½ the sample having a first-degree relative with a confirmed diagnosis of a severe and persistent mental illness. In terms of occupational status at intake, only 10 individuals were participating in multiple age appropriate spheres such as school part-time work, and social-leisure; whereas 1/3 of the sample was already isolated from and not engaged in any of the above.

<Table 7.1>

Three individuals met criteria for pre-psychotic symptoms while the remainder was experiencing a first episode of psychosis with average durations of untreated psychosis of less than 6 months. Of these 62 individuals, 35 had a long-term diagnostic outcome of schizophrenia (56.4%). Table 7.2 outlines the diagnostic accuracy of the Azima Battery (85%) in comparison to the initial diagnosis posed by the treating psychiatrist (31%) in the overall sample, per diagnosis. The modal amount of time between the psychiatrist's intake interview and Azima Battery evaluation was 1 week. There were no significant differences in diagnostic accuracy between the nine prospective individuals (88.9%) and the overall combined sample.

<Table 7.2>

The sample was then divided into those with (n=35), and those without a final diagnosis of schizophrenia (n=27), creating a dichotomous outcome. The initial diagnostic impressions of the psychiatric interview and the Azima Battery were tallied into a 2 x 2 table to measure predictive validity (Streiner & Norman, 2008). The initial diagnostic impression of schizophrenia was coded as present or absent with respect to the final 1-year or more diagnosis of actually having schizophrenia or not for each subject (see Table 7.3). For example, if the initial diagnosis was present for schizophrenia, and the final diagnosis at 1-year was also a 'true' schizophrenia then this was logged under the cell for both present and true.

<Table 7.3>

Using these cells with a dichotomous outcome, values relevant for predictive validity were calculated. Sensitivity, specificity, and positive and negative predictive values for both the psychiatrist's initial diagnosis and the Azima Battery clinical impression in relation to 1-year diagnosis or schizophrenia can be found in Table 7.4. The Azima Battery outperformed traditional psychiatric diagnostic interviewing in terms of detecting incipient schizophrenia at intake into early psychosis services.

<Table 7.4>

The second aim of this study was to identify combinations of performance items associated with a final diagnosis of schizophrenia. Using a rigorous descriptive phenomenological approach to generating items, a final total of 64 themes-as-variables were thus described for the five expressive tasks and the Azima Battery as a whole. Of these 64 variables, 20 were identified as clinically relevant due to statistical significance when treated as nominal variables, and supported by prior scientific literature. Table 7.5 provides a representative description of these quantified nominal variables. The significantly predictive variables per task were ordered and strung together into patterns of performance for each subject. The frequencies of these strings were comparatively calculated for those individuals with, and those without, schizophrenia.

<Table 7.5>

In relation to overall performance across the five tasks, only those with a diagnosis of schizophrenia demonstrated a pattern of increasing fragmentation across the five tasks. That is, as task structure decreased and became more expressive with the clay and the finger-paint, the subset of individuals early in the process of developing schizophrenia were disorganized and created objects that were not coherent, or complete. For those who were organized in their process of creation, only those with schizophrenia demonstrated a pattern of final objects that were fragmented along with human figure drawings represented as either floating eyes and heads, and/or depicting male and female figures that are undifferentiated or indistinguishable from each other (n=18 of the 35 individuals with schizophrenia). This pattern of increasing fragmentation across the evaluation session was not observed in any of the individuals not diagnosed with schizophrenia (n=27).

In terms of the human figure drawing tasks, the following trends were noted. Figures that were depicted as static or rigid with minor to major perceptual issues were seen in the productions of 13 (37%) individuals with a diagnosis of schizophrenia compared to three (11%) not diagnosed with schizophrenia. In addition, six of the individuals diagnosed with schizophrenia (17%) placed the flat, static figures significantly off-centre in a quadrant of the page. This combination was not seen in the other group.

With respect to the clay task, no definitive pattern was found to be statistically exclusive to individuals with schizophrenia. Although, it is worth noting that the perceptual anomalies may be diagnostically key in the clay task. No perceptual anomalies were observed in the group not diagnosed with schizophrenia. Conversely, more individuals with schizophrenia (n=7; 20%) demonstrated higher numeric scores indicating greater patterns of dysfunction within the combination of perceptual anomalies, odd content, and disorganization. Only one individual without a diagnosis of schizophrenia demonstrated this higher numeric pattern score. Therefore, within the clay task it may be that the organizational demand to structure a three-dimensional media is a challenge for those with core features of schizophrenia.

For the finger-painting task, while equal numbers (3 in each group) showed no issues on any significant variables, 19 of the 35 individuals diagnosed with schizophrenia (54%) showed some degree of the following performance combination: difficulty problem-solving what they wanted to create and creating a very simple or poorly executed finger painting with odd or idiosyncratic content. It should be noted that six

individuals (22%) with a non-schizophrenia psychiatric diagnosis also demonstrated the same performance pattern although coded with lower (less dysfunction) numerical strings.

Overall, pattern combinations were descriptively noted to be of interest within each of the five tasks, and in terms of overall performance during the Azima Battery session. However, no specific combination of performance items emerged as prescriptive of a future diagnosis of schizophrenia.

7.5. Discussion

This clinical study examined the comparative ability of two intake evaluations to detect incipient schizophrenia in youth seeking help for early psychosis. The results demonstrate the greater predictive validity of the Azima Battery in comparison to traditional psychiatric interviewing. Providing the client with the opportunity to engage in unstructured expressive tasks using art media facilitates key observations of the structure of their experience as manifested in the process and outcome of their activity performance. Whereas the accuracy of the psychiatrist's initial diagnostic impression fell within the range reported in the literature for this population (Rahm & Cullberg, 2007), the Azima Battery outperformed the diagnostic accuracy of routine clinical psychiatric diagnostic interviewing. Participants in this study had demographic characteristics comparable to other individuals upon admission to early psychosis services (Henry et al., 2007).

The findings reported here support the research to date on the utility and validity of qualitative, phenomenological interviewing approaches to accurately detect incipient schizophrenia (Møller, 2001; Nelson et al., 2008; Raballo & Parnas, 2012). Other studies have also supported the diagnostic promise of using a projective test with clients in early psychosis (Kalla et al., 2004; Louet et al., 2010). Broadly speaking, the use of phenomenological diagnostic interviewing and verbal (not activity-based) projective tests perform similarly with a recurrent approximate 70% rate of diagnostic accuracy or sensitivity for a future confirmed diagnosis of schizophrenia (Ilonen et al., 1999; Klosterkötter et al., 2001). In this study, the Azima Battery, an occupational therapy projective assessment, was found to be more accurate and sensitive than what has been reported in these other studies.

Part of the hypothesized reason for the greater predictive ability of this occupational therapy evaluation tool is the opportunity to observe elements of activity performance that are expressive of the phenomenology of schizophrenia. Thus, the secondary aim of this study was to identify and examine patterns of performance distinctive for a long-term diagnosis of schizophrenia. In this sample, individual nominal variables related to the structure of the activity performance and the final created object were significantly correlated with a final diagnosis of schizophrenia. The five items (Table 7.5) with the highest correlations in this study are not novel and have been reported in case illustrations and small sample ($N<20$) studies of the artwork of individuals with early schizophrenia. These observed elements are: 1) fragmentation (Amos, 1982; Billig, 1969), 2) emptiness of created objects or figures (Harrower, 1958/1980; Weiner, 1966), 3) over-emphasis on eyes and lack of sexual differentiation in the figure drawings (Arieti, 1958/1974; Hammer, 1958/1980; Ogdon, 1977), 4) perceptual difficulties with three-dimensional clay media (Goodman Evaskus,

1982), and 5) static temporality or lack of motion (Hammer, 1981; Wenck, 1970). Thus, due to the larger sample size in this study (N=62), the similar findings become even more significant.

While no final definitive pattern of combination of performance items could be demonstrated, descriptive trends were found potentially distinctive for a final diagnosis of schizophrenia. Specifically, patterns that combined items related to the structure or process of observed performance and the created object (e.g. sequence of organization, perceptual unity, coherency or fragmentation of objects, complexity of created object) were found. Thus, it is not a combination of exact prescriptive signs within the structure of activity performance, but "rather, it is the configuration of signs utilized in conjunction with the therapist's experience of the person" (Amos, 1982, p. 142), within the whole of the evaluation session that need to be taken into consideration to account for the high positive predictive value (93.75%) of the Azima Battery. The whole projective profile includes what was created and how, as well as what was said and how, within an expressive and engaging mode of evaluation. Therefore, one interesting avenue for future research would be to articulate the expert clinical reasoning that underpins the administration and interpretation of the Azima Battery as a whole evaluation process. In addition, research with larger sample sizes would allow for greater statistical detection of possible projective performance patterns distinctive for a final diagnosis of schizophrenia. Finally, this study used a dichotomous diagnostic outcome for schizophrenia. Larger samples would also allow for more fine-grained analysis of the discriminant validity of the Azima Battery in detecting and differentiating other psychiatric disorders in an early psychosis population.

Limitations of this study included the naturalistic retrospective data collection process. Although this supports the ecological validity of the results, it does mean that only one occupational therapist's use of the Azima Battery was compared to multiple psychiatrists' diagnostic interviews within the everyday of clinical work. Therefore, it is not known to what degree the expertise of the occupational therapist administering the Azima Battery was associated with the study results. The coding process for the performance items was not intended to become a scoring procedure, thus the nominal data, while remaining close to the descriptive analysis, constrained the type of statistical analyses that could be used. As well, the phenomenological analyses in a qualitative sample of nine participants may not have reached theoretical saturation for all possible performance variables.

7.6. Implications for practice

This study validates the diagnostic use of an occupational therapy expressive assessment, the Azima Battery, with youth accessing early intervention for psychosis services. As such, it highlights a promising avenue to improve diagnostic accuracy of schizophrenia and ensuing interdisciplinary treatment choices. This study has important implications for clinical practice. First, the results add to the literature that raises questions about the epistemologies of diagnosis, and the way in which the psychiatric diagnosis of schizophrenia is evaluated from differing perspectives such as medical vs. phenomenological. Second, the Azima Battery, in line with phenomenological psychopathology, places an emphasis on eliciting, observing

and understanding the structure of the individual's experience. Therefore, occupational therapists working in mental health need to be aware of phenomenological psychopathology as an important alternative to biological psychiatry, particularly as an approach for projective case formulation. In spite of their long history and clinical utility with help-seeking youth, the use of expressive projective assessments in diagnosis and detection remain marginal in current occupational therapy practice and research (Zafran & Tallant, 2015a). Further, beyond detection and diagnosis, it is argued that a phenomenological approach to the Azima Battery is in line with recovery-oriented guidelines for evaluation (Slade, 2009; Zafran & Tallant, 2015b). Thus, there is a need to continue developing the research base for the Azima Battery as well as to develop and maintain the educational preparation required to administer and phenomenologically analyze this form of evaluation process in occupational therapy curricula.

7.7. Key Messages

1) The Azima Battery is a projective assessment with high predictive validity for incipient and early schizophrenia

2) Diagnostic accuracy is promoted by observing the structure of patterns of performance in the projective tasks and created objects

3) The phenomenological use and interpretation of expressive assessments should be maintained, developed, and researched in occupational therapy curricula, and promoted for clinical use particularly in early psychosis intervention programs.

Table 7.1: Sample Characteristics at Entry to Early Intervention Services (N=62)

	Mean (SD)	Range
Age	22.85 (4.2)	15-35
Male	22.8 (3.8)	
Female	23 (5.2)	

	N	%
Gender		
Male	46	74.19%
Female	16	25.80%
Immigration status		
First Generation to QC	35	56.50%
Second Generation to QC	10	16.10%
Other province to QC	4	6.50%
From Quebec (QC)	13	20.96%
Family psychiatric history		
None	21	33.87%
Second degree relative	10	16.10%
First degree relative	31	50.00%
Adverse Life Events		
None	14	22.58%
After age 20	5	8.06%
Childhood event(s)	10	16.13%
Adolescent event(s)	15	24.19%
Continuous	18	29.03%
Education		
Graduate in progress	4	6.50%
Undergraduate completed	9	14.50%
Undergraduate in progress	26	41.93%
Highschool completed	12	19.35%
Highschool dropped	11	17.70%
Socioeconomic status		
Above poverty line	46	74.40%
At or below poverty line	15	24.20%
Occupational Status		
High participation	10	16.10%
Moderate participation	33	53.20%
Low participation	18	29.03%

TABLE 7.2: COMPARATIVE PREDICTIVE ACCURACY OF FINAL DIAGNOSIS

Final Diagnosis	N	# correct Psychiatrist's Initial impression	# correct Azima Battery Case formulation
Schizophrenia-spectrum	35	13	30
Psychosis NOS/NYD	2	2	1
Primary Depression (with or without psychosis)	3	0	3
Trauma (PTSD, adjustment disorder)	1	0	1
Mania (bipolar, hypomania, with or without psychosis)	4	2	4
Anxiety (GAD, social phobia)	8	1	5
Primary substance use/induced state	2	1	2
Personality Disorder – Cluster A	2	0	2
Personality Disorder – Cluster B	4	0	4
Learning disability	1	0	1
Overall diagnostic accuracy	N=62	31%	85%

Table 7.3: Comparative 2x2 tables to evaluate predictive validity for a diagnosis of schizophrenia (scz)

		Final diagnosis		
		True Scz	**No Scz**	
Psychiatrist's initial diagnosis	**Scz present**	13	14	27
	Scz Absent	22	13	35
		35	27	

		Final diagnosis		
		True Scz	**No Scz**	
Azima Battery case formulation	**Scz present**	30	2	32
	Scz Absent	5	25	30
		35	27	

TABLE 7.4: COMPARATIVE PREDICTIVE VALIDITY FOR LONG-TERM CONFIRMED DIAGNOSIS OF SCHIZOPHRENIA

	Psychiatrist's Initial diagnosis	Azima Battery Case formulation
% Accuracy	41.90%	88.70%
Sensitivity	37.10%	85.71%
Specificity	48.10%	92.59%
Positive predictive value	48.10%	93.75%
Negative predictive value	37.10%	83.30%

Table 7.5: Illustrative sample of performance items significantly correlated with a final diagnosis of schizophrenia

Variable	Description	Coding	Correlation (*)
Fragmentation	Extent of coherency of created object	1. Objects are coherently created overall 2. Fragmentation present in figure drawing tasks 3. Fragmentation present in expressive tasks 4. All objects are fragmented	0.306
Emptiness within the draw a person	Extent of detailing within the object and/or the surround	0. Object has details, even if floating 1. Empty – devoid of details, minimalist	0.278
Draw a person of the opposite sex-perceptual	Presence of perceptual incoherencies within the human figure drawing e.g. flatness, perspectival distortions, problems with spatial relations or figure ground	1. No gross perceptual issues 2. Minor perceptual distortion 3. Major perceptual distortion	0.360
Clay sequence of creation	Concept formation, anticipation, ability to initiate, logic of sequencing of performance regardless of quality of final product	1. Organized -no issues 2. Disorganized – jumps around, unsure of goal 3. Major aberration of performance- catatonia	0.314
Complexity of fingerpainting (FP)	Efficiency and quality of performance and created object	1. Quickly creates a complex FP 2. Slowly creates a complex FP 3. Poorly executed complex FP 4. Creates a simple idea 5. Poorly executed simple FP	0.406

(*) significant r for Phi & Cramer's V ($p<0.05$)

Range of r values for N=64 variables: 0.015-0.406

Linking Statement

"Man is the Storytelling Animal, and that in stories are his identity, his meaning, his lifeblood"
(Rushdie, 2010, p. 34)

When used with youth seeking help for a potential first episode of psychosis, the Azima Battery is a clinically valid assessment tool. The case formulation that emerges from an occupational therapist's clinical analysis of the projective activity performance is capable of accurately detecting a future diagnosis of schizophrenia. The hypothesized reasons for this include (i) the opportunity to observe performance ability in unstructured expressive tasks, and (ii) the phenomenological epistemology of the evaluation process. While the revealed or expressed structure of performance is certainly a key and central element (Arieti, 1958/1974; Hammer, 1958; Marcus, 1992), it remains one part of the 'whole' of the evaluation session.

The orientation towards observing and interpreting both activity performance as well as the whole of the session is framed by a phenomenological way of knowing and relating. It has been argued that the use of visual phenomenology, or a phenomenological approach applied to artwork, highlights that experience is a mode of interactive engagement and that expressive artwork reflects this interaction (Noe, 2000). A phenomenological approach reveals both mode-of-being as well as concerns and coping (Dreyfus, 1991), while trying to orient towards that which matters to an individual in their world (Benner, 1994). Thus, expressive art is a form of gestural narrative, and in the Azima Battery, is accompanied by exploratory story sharing. This can reveal identity within a given life world (Dewey, 1934/1980).

In the following manuscript a hermeneutic phenomenological analysis of the Azima Battery evaluation session conducted with nine young adults recently admitted to early psychosis intervention services is presented. The epistemological framework is outlined within the methods as well as illustrated in the findings, and contributes to further articulating this way of knowing for the clinical reasoning of occupational therapists. The findings illuminate how the (pre)psychotic experience emerges through action and in narratives, and how these participants create meaning out of their experiences within the context of their life stories. The Azima Battery is an approach to evaluation that is found to be therapeutically engaging and clinically useful.

Chapter Eight (manuscript)

The phenomenology of early psychosis elicited in an occupational therapy expressive evaluation

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8.1. Abstract

The use of an expressive assessment to elicit and understand the structure and meaning of experiences is in line with recovery oriented policy for youth mental health evaluation. The experiences of nine young adults of varying immigrant status seeking help for psychosis were explored through the use of an arts-based expressive evaluation, the Azima Battery. The study used participant-observation methods within an occupational therapy clinical consultation that was videotaped. Data analysis drew on hermeneutic phenomenology in occupational therapy, anthropology, and psychiatry to understand narrative, actions, and experience. The findings illustrate the interpretation of the nonverbal expression of experience through art media, as well as a deeper understanding of the concerns of the nine participants. The primary themes highlight the challenges these participants have in feeling connected to a shared world of doing, and in locating themselves within the temporal flow of time. For these participants, the sense of alterity was not only related to pathology, but also to significant life events surrounding migration and parental mental illness. These life events continued to reverberate in the present as an ongoing experience of difference rooted in temperament, ethnicity, and/or childhood trauma. Of significance was the potential to read the unfolding of creation in clay media as an acted narrative, in order to tap into constellations of meaning and the participants' mode of relating to what matters most to them. The clinical implications and theoretical utility of such an analytic approach are discussed. There is a need to cultivate such interpretive frameworks in the education of occupational therapists.

Keywords

Hermeneutic, Clinical Reasoning, Acted Narrative, Metaphor, Intentionality, Temporality

8.2. Introduction

> "Time is a River, not a clock, and it can flow the wrong way, so that the world becomes more backwards instead of less, and that it can...loop and twist and carry us back to yesterday or forward to the day after tomorrow."
> (Rushdie, 2010, p. 159)

The move towards recovery oriented care has placed a focus on lived experience (Mental Health Commission of Canada, 2009). This has been supported by phenomenological approaches to psychopathology (Sass, Parnas, & Zahavi, 2011; Stanghellini, 2011), psychiatric therapy and rehabilitation (Chadwick, 2007; Nelson, Sass, & Skodlar, 2009; Perry, Taylor, & Shaw, 2007), and occupational therapy (Ivarsson, Söderback, & Ternestedt, 2002; Sutton, Hocking, & Smythe, 2012; Zafran et al., 2012). Phenomenological approaches are concerned with illuminating the structure and meaning of lived experience (Harland, Morgan, & Hutchinson, 2004). These approaches are relevant for early intervention for psychosis, a gold standard of care that aims to promote the recovery of adolescents and young adults (Mental Health Commission of Canada, 2012; World Health Organization, 2012). The phenomenological focus in this domain of health care is concerned with reconceptualising the living of psychosis from an experiential point of view that is grounded in philosophies of personhood (Lysaker & Lysaker, 2005; Parnas, 2011), while simultaneously acknowledging the challenge in accessing, verbalizing and comprehending the otherness of the psychotic experience (Chapman, 1966; Davidson, Staeheli, Stayner, & Sells, 2004; Kirmayer, 2008b).

The term 'psychosis' derives from the Greek and speaks to an abnormal derangement of the mind. Yet, this is an inversion or play on the original meaning of the term *psykhosis* pertaining to that which animates, referring to the soul or principle of life (Harper, 2001-2014). Existential analyses of the experience of psychosis describe individuals as having lost contact with vitality and the flow of time (Minkowski, 1927). Thus, the historical cluster of meanings that surround the term and interpretation of psychosis are grammatically and figuratively located in our horizons of personhood, and what vitally moves us forwards in our lives. When self-experience is first disrupted, as it is in early psychosis (Parnas, 2000; Parnas et al., 2005), it can be extremely difficult to speak of one's own experience. This can be compounded in a context of being taken into psychiatry and acquiring (or resisting) a stigmatizing label (Larsen, 2004; Saks, 2007), coupled with the developmental ability to reflect on and share one's experience in adolescence and young adulthood (Harrop & Trower, 2003). Researchers and therapists need to resort to multiple modes of knowing and listening to youth in a psychotic state, such as paying particular attention to the nonverbal relational space between self and other (Atwood, Orange, & Stolorow, 2002; Kossak, 2009), accompaniment in daily activities (Larsen, 2007b), or through the use of expressive media that facilitate alternate avenues for communication and sharing (Reynolds, 2008; Thompson & Blair, 1998).

Expressive assessments use art media to facilitate communication through creative doing. The creation of an object that taps into an individual's experience allows both the therapist and the client to co-construct a narrative around an object. This can provide a reflection or projection of the individual's mode of being (Gunnarsson et al., 2006; Saint-Jean & Desrosiers, 1993). Further, in occupational therapy, the 'central

position of the object' (Azima & Azima, 1959) elicits observations of the way the individual creates and relates to the expressive object. The unfolding of the process of creation is a non-verbal expression of the person's mode-of-being through expressive doing at that moment in time (Arieti, 1958/1974). Analyzing this performance of an activity within a therapeutic relationship is an occupational therapy specific competency. In empirical explorations of occupational therapy clinical reasoning, Mattingly has described the phenomenology of therapeutic activity as one of an 'acted narrative' (Mattingly, 1998a). That is, both the structure and meaning of experiences emerge in both words and actions that are interpreted and engaged with as a narrative or story-telling plot (Fleming & Mattingly, 2000; Mattingly, 1994). Clinical experts have argued that this is particularly so in unstructured, or ambiguous, expressive media (Zafran & Tallant, 2015b). Thus, the use of expressive assessments in occupational therapy with youth experiencing a first episode of psychosis provide an opportunity to phenomenologically understand the structure and meaning of their experiences.

In Canadian occupational therapy, the first expressive assessment was created to facilitate communication and understanding with individuals experiencing psychosis. The Azima Battery asks the participant to create five objects in three different media (pencil drawings, clay, finger-paint) within a standard setup. Each creative task is followed by a period of open-ended phenomenological interviewing (Cramer-Azima, 1982). The aim of this study was to elicit and interpret the psychosis experiences of youth as part of an initial intake into early intervention for psychosis, through the use of an occupational therapy expressive evaluation process (the Azima Battery). This was to (1) deepen the understanding of the experience of help-seeking youth and (2) explore and illustrate the use of a hermeneutic phenomenological analysis in an expressive evaluation.

8.3. Methodology

This qualitative study is situated within an interpretive paradigm. It uses a participant-observation design that draws on the operationalization of hermeneutic phenomenology in occupational therapy, anthropology, and psychiatry to understand narrative, actions and experience. Phenomenology is an interpretive approach to exploring how our ways of being in the world are inextricably bound up in everyday doing (Dreyfus, 1991). As such, it articulates an ontology of the in-between whereby truth about phenomena emerges from between people (e.g. interviewer and participant), between the participant and their created object, and between the parts and the whole of a text (e.g. a transcript and across transcripts, between one created object and the next). It is an approach that acknowledges the particularity of a person's history and sociocultural world(s) (Desjarlais & Jason Throop, 2011). Our ways of doing (in particular here, expressive doing) reveal as well as mould our ways of being (Davey, 2006; Park Lala & Kinsella, 2011b). In this study, the intersubjective role of the researcher in eliciting and interpreting the experience of others is acknowledged (Finlay, 2009).

8.3.1. Sampling

This clinical study took place within a Canadian urban university teaching hospital that had created the first early intervention services for psychosis in that city in 1997. Ethical approval was obtained from both the associated university as well as the hospital review board. The sampling for this study was purposive and small (maximum of 10), in order to focus on depth of analysis with participants who had the phenomena of interest in common (Smith, Flowers, & Larkin, 2009). Thus, the study sampled help-seeking individuals 14-30 years of age receiving early psychosis services for less than three months. The basis for inclusion was participants who met the Melbourne criteria for risk of psychosis (Parker & Lewis, 2006), or were experiencing their first episode of psychosis. That is, they might have been experiencing prepsychotic or brief or intermittent psychotic symptoms, or a confirmed transition into first-time psychosis, and/or exhibiting a decline in psychosocial functioning combined with having relatives diagnosed with a psychotic-spectrum disorder (McGorry et al., 2003). Exclusion criteria included psychotic features secondary to an identified neurological cause (e.g. epilepsy) and/or incapacity to consent to the research process as evaluated by the treating psychiatrist. Potential participants were referred as meeting these criteria, with no other biographical or psychiatric information, in order for the researcher to maintain an open-minded stance.

8.3.2. Occupational therapy expressive evaluation process

The Azima Battery is composed of five tasks in three media and has a standard set-up, sequence, and opening instructions for the tasks (Azima & Azima, 1959). This is a general structure within which there is great flexibility for exploratory, phenomenological questioning that follows the participant's lead (Cramer-Azima, 1982). The interviewer and participant sit side-by-side at a table (rather than face-to-face). In front of the interviewer are pencils, an eraser, paper sheets for drawing and finger paint (12"-18"). Lined along the top of the table are bottles of finger paint in six set colors, a sponge and bowl of water, and a three lb. ball of red clay.

Following an introduction to the evaluation that focuses on art media as a means of communication rather than artistic ability, the interviewer hands drawing paper, pencil and an eraser to the participant and asks them to 'draw anything that comes into your mind'. The following task is to 'draw a person', then 'draw a person of the opposite sex'. This is followed by the more expressive, or tactile, tasks. After the drawings the participant is offered a 3 lb. ball of clay out of which they can make any object of their choice, and finally, to create a painting using their fingers. Participants are told that they have no time limit for their creations, and unless they initiate conversation, this occurs in silence with quiet observation by the interviewer. Following each task an open-ended period of interviewing begins with 'tell me about what you have made'. This phenomenological interviewing focuses on the experiences elicited by the process of creation, the meaning attributed to the object, and safely exploring the associated experiences and memories that emerge, while honing in on the particulars of the individual's narrative (Davidson, 2003a) as well as the created objects.

8.3.3. Data collection

Approximately 30-40 individuals are referred annually to the specific study site (Zafran & Laporta, 2008), all of whom meet the study criteria (Nolin, Malla, Tibbo, Norman, & Abdel-Baki, 2016). Between 2011-2013, twelve individuals, speaking either English or French, and newly admitted to early psychosis intervention services were prospectively identified by treating psychiatrists as competent to consent and interested in the study. Nine of these referred individuals consented to participate in a videotaped Azima Battery evaluation session with me, the author. These sessions were scheduled at times convenient for the participants already attending medical appointments, and took place in the occupational therapy department within the same building. The occupational therapy evaluation process was offered as a clinical consultation within the early psychosis psychiatric service. Open communication with the treating team was included in the consenting process; therefore, pertinent clinical information for case formulation was shared with the attending psychiatrist and case manager after the research evaluation session.

Following the completion of the videotaped expressive evaluation, a short questionnaire of demographic and occupational information (such as current school, social and/or work involvement) was collaboratively filled out. Following the session I (the author) spent time recording reflective thoughts in research memos. A research diary and field notes were also maintained throughout the research process. Three graduate occupational therapy students transcribed the video recordings. The attendant verbatim transcripts were double-checked for accuracy, and considered data along with the objects created by the participants, and the reflective memos, research diary, and field notes kept by the author.

8.3.4. Data analysis

I was immersed in hermeneutically analyzing the multiple forms of data over the three years that the study was active. This immersion involved attendance to what was said, how it was said, what was created, how it was created, as well as the intersubjective experience of conducting the evaluations. Videos were viewed at first with sound, and subsequently without sound to improve attendance to body language, facial expressions and actions. The verbatim transcripts were annotated for paralinguistic, temporal, and observational markers such as *'leans in to remould the clay…15 second silence…'*. The first approach to the analysis involved noting significant (micro)events (Jackson, 1998, 2005; Mattingly, 2010a; Stern, 1985) between participant and interviewer, such as transitions in mood or verbosity, as well as events between the client and the creation of their art object, for example shifts in rhythm or body language. Through this process of immersion a sense was formed of each participant's key concerns, what was meaningful to them, their narrative structure, and ways of expressive doing.

This was followed by a deepening of the analysis, which involved a detailed and thorough description and interpretation of each session and the various forms of data while paying attention to the researcher's (author) initial thoughts and assumptions. Further, noting how these assumptions were influencing what was revealed or concealed in the emergent interpretations, that is, engaging in the hermeneutic circle to articulate

pre-understanding (Laverty, 2003). Participant narratives and objects were attended to in terms of the metaphors, cultural resources, aesthetic, and bodily qualities of experience that they revealed (Kirmayer, 2004; Mattingly & Lawlor, 2001; Park Lala & Kinsella, 2011a). Significant elements, themes, phrases and observations were noted and fleshed out within and across participants. These parts were integrated into a sense of the 'whole' for each participant, and across participants, in a hermeneutic cycle where each conceptualization of the 'whole' in turn shifted the interpretation of the parts, and back again.

This analytic process was interlaced with dialogue with my doctoral committee, analytic and creative (poetic) writing (Kinsella, 2006b; Milligan & Woodley, 2009), and by further reflection on the constant moving between the parts and the whole for each participant. Ongoing reading of empirical, literary, and philosophical texts related to phenomenology, occupational science, and first person accounts of the experience of psychosis also supported this interpretive process. This movement of deepening understanding allowed for the emergence of an over-arching grasp of how each participant's way of being was linked to their horizons of meaning in their current situation and particular histories (Alvesson & Sköldberg, 2009), and how this was revealed through expressive doing and narrative sharing. These themes were acknowledged to be possible interpretations, and I remained open to other ways of understanding the data (Kinsella, 2006a). This was facilitated through the presence of a purposefully composed reflection team.

In terms of the trustworthiness of the findings, in the first year of data analysis, three experts in the realms of occupational science, phenomenological psychiatry, and qualitative research participated in the observation (n=10 sessions; 19 hours) and analysis of the videotapes. They contributed to the maintenance of a reflexive stance, depth of interpretation, and rigor in qualitative analysis through dialogue (Kinsella, 2012b). The use of purposeful naturalistic sampling increased the possibility for transferability; which, coupled with detailed descriptions, allows a reader to judge for themselves the relevance of the findings.

8.4. Findings

Over the course of two years (2011-2013) twelve individuals were referred to this study, of whom nine consented to participate in a videotaped expressive evaluation, the Azima Battery. They had all been admitted to an early intervention for psychosis service in the month prior to participating in the research session. The expressive evaluations lasted approximately three hours on average (1.5-4.5 hours long). The participants were 18-28 years old, and included five women. Five were first generation migrants, two were second-generation migrants, and two had recently moved from other parts of Canada. Five of the nine participants had a significant family history of severe mental illness, and six reported adverse life events such as abuse or neglect, poverty, or war trauma. Five of the participants had experienced these adverse life events in the context of a parent having a severe mental illness. Only one participant presented with current substance use (Tariq), and one had used substances in the past (Dinesh). A description of the participants and their current occupational status can be found in Table 8.1, in the order in which they were interviewed. Pseudonyms have been assigned and salient features such as country of origin, exact age, and specific

occupational details have been de-identified in order to preserve confidentiality. The final column of the table outlines significant life experiences that the participants self-identified as important to them, and of ongoing concern. These are summarized in brief in Table 8.1 for the reader to better situate the illustrated themes below.

<Table 8.1>

The following findings are a selection of the most striking and consistent themes interpreted for all the participants. The first three themes focus on understanding the participants' experiences of psychosis while the fourth theme relates to occupational therapy clinical reasoning in understanding what is meaningful for the participants. For each theme, the reader is provided with a brief overview of the analytic concept as synthesized from the relevant empirical and philosophical literature. This is followed by illustrative data. These illustrations are provided in a 'whole of the parts' for a participant rather than snippets from each participant, to maintain fidelity to a hermeneutic analysis, as well as for clarity.

8.4.1. Tenuous intentional arc

Intentionality is the notion that all consciousness or mental thought is about or towards something or someone (Parnas, 2000). Rather than focusing, though, on the potential psychological or mental content of the participants' minds, a phenomenological approach deepens this concept to refer to an orientation towards the world around us, a mode of turning towards being and engaging in the world, while also being constituted by it (Davidson et al., 2004; Park Lala & Kinsella, 2011b). Thus, intentionality becomes a verb, a mobile intentional arc that orients self-in-the-world (Merleau-Ponty, 1945), or the experience of being 'called' by a meaningfully shared world (Reed, Hocking, & Smythe, 2010). The notion of an intentional arc is particularly salient in the experience of psychosis, if psychosis is first and foremost understood to be the loss of contact with reality (Parnas, 2011), a disconnection from the world around us. This tenuous intentional arc was described by the participants in moments of being disconnected from the process of drawing, or in relation to the content of the created drawings. I also experienced this during the evaluation session as a peculiar sense of being either an object or audience to the participant, as emotional or gestural expressions of interest, fatigue or surprise remained unregistered or unacknowledged by the participant. Participants explicitly narrated their difficulties with connecting and moving towards their worlds, or in sensing that people and activities might pull them out of their inner experience.

Naoko comes thrilled to participate in the study, *"I LOVE Art!"* She shows up dressed all in pink, with a cartoon character on her t-shirt. She has a deep voice with expressive variations in pitch and cadence that dramatically modulate her narrative. In spite of her expressed enthusiasm and total investment in all the media and process of creation for over four hours, Naoko mentions *"losing interest"* in what she is making while making it, and uncertainty about where her created images and forms have come from, *"somehow these words dropped onto the paper and then I'm like 'ooohhhh' where did that come from?"* She in particular cannot connect to her first drawing of floating faces, symbols and fragmented ideas, nor her final abstract finger painting in

multiple colors and squiggles. She pushes away these creations, covers the drawing while changing the subject, at times perplexed at what she has made. In these moments she speaks of herself and her process in the third-person, as if it is an 'Other' who has engaged in the activity.

Leanne comes dressed professionally from school, in a shirt and cardigan. Her voice is lilting and soft, and she keeps the same, even, moderated pace throughout the three hours we are together. Leanne's creations reveal a highly organized individual who is able to think of, and make, well thought through and complex objects such as the drawing of a detailed scene in a park by a lake, complete with shaded bench, trees and birds. Yet, she too, sits perplexed in front of her three drawings, wondering where they have come from, describing both the scene and her figure drawings as *"cold… distant… Hmm… I guess I don't really have any thoughts or attachments to this person…I can't really explain it"*. She herself relates this uncertainty to a more profound challenge in experiencing what she may be drawn to, or called by. *"Um… sometimes I almost feel guilty for it when I honestly don't have a preference. Like, sometimes when people try to make you choose… it's frustrating because you feel almost like they think you just don't care, but really it is just that…whatever"*. Leanne describes years of retreating into bed, simply because there isn't much in the world around her that pulls her out. "*I just felt horrible all of the time. And I would do things because I had to be doing something. I never actually wanted to do anything."* This description of her lived experience stands in stark contrast to her academic achievements that include obtaining full scholarship grants and attending graduate school. Yet, Leanne continually describes her experience as that of a *"lump"*, one that has great difficulty reaching out into the world and to those around her. Leanne says she is *"very much the type of person that I kind of… leave it to the other person to initiate anything"*. Leanne's nature scenes in pencil, clay and finger-paint are devoid of people, and her figure drawings are anonymous and unidentified. She appears nowhere in her work.

In two poignant instances, stark breaks in intentionality were observed when both Dinesh and Priscilla minimally drew empty circles after much trying and thinking. Both were unable to respond to either closed or open-ended questioning to elaborate on their drawings.

8.4.2. Frozen temporality

Leanne describes the experience of disconnection from a shared world or from pleasurable doing as one of *"passivity…floating along"*. This sense of being untethered from a daily rhythm, of not being pulled into or called by the world is bound to the sense of time being frozen, of not passing by. Heidegger's treatise on *Being and Time* places temporality – the subjective experience of time – as the horizon within which affectedness (finding things and ways of doing that matter) occur (Dreyfus, 1991). Psychosis seems to have thrown these individuals into 'stuckness'. The sense of time being slowed or static was observed with all participants creating immobile human figures and/or animal productions that were described as not going anywhere, along with at least one of the following: (a) narratives 'stuck' at one particular experiential moment in time (b) bodily freezing in time during the process of creation (c) sessions occurring without the participants having an awareness of time passing, increasingly notable during the tactile clay and finger-

painting tasks, and (d) descriptions of the inability to move forward into the future, with existential and identity implications, as described in the next thematic section.

Clementine is a rapid speaking francophone with a Spanish lilt in her voice. Her ponytail bounces as she speaks, and even though she speaks quickly and a lot, she often stops to yawn and her eyes droop. She attributes this to being on medications for the first time. Like the other participants, Clementine loses herself in the process of creating. While different descriptions and stories initially emerge for each of her five creations, over the course of three hours Clementine invariably circles back to the year prior to her hospitalization. She describes this partly in the third-person, when *"nobody recognized me, like, plenty of people said it's not the Clementine we know, like, we don't know you anymore…and then, at the end of the year, half-dead like…everyone was wondering when she would, like, return to normal."* Although activities and events have occurred since her decline into psychosis, including a successful hospitalization and resuming classes in a new college, Clementine's experience is frozen in this part of her 'unfolding story' (Bruner, 2002). She is certainly searching for meaning in what has happened, returning to the chronology of events. She is particularly focused on narrating having a mother with a mental illness who lost custody of Clementine when she was eight years old. Yet it was her mother who was the one who stepped in and made sure she got the help that she needed. However, beyond narrating this mother-daughter relationship, Clementine subtly continues to literally be stuck in that moment in time, in that of descending into depression and psychosis. Although Clementine appears to now be making plenty of efforts, the outer markers of movement forwards are not matched by an inner experience of a fluid temporality. She remained at the time of the evaluation, stuck in that year of despair: *"Well now, I, I still have nightmares, I never have like nice dreams. I'm never at ease since I've come out of that, I never sleep well. It's always dreams that like finish…that go bad."*

Of the nine participants, Nathan literally embodied a frozen temporality in the most visible manner. On the behest of his sister, Nathan had moved from Western Canada three months prior, and had only been seen in psychiatry twice when he came to the evaluation session. He had just found out that his years of living in his father's basement were due to 'psychosis'. He was beginning to creatively write again, and he brought a published comic book that he had written a few years prior, to share with me. Although he was 24 years old, Nathan appeared much older. He sat through the 3.5 hours session with some gestural arm movements, deep sighs, and looking my way a few times. His torso remained mostly fixed in his chair, his gaze lowered at the table in front of him. Throughout the process of creating his five objects, Nathan demonstrated a start-stop-start rhythm. That is, he would be leaning in, drawing a line, imperceptibly stop drawing or moving, then continue. This rhythm remained throughout, with a peak event midway during the session. Nathan was asked to 'draw a person of the opposite sex' and his response was just over six minutes of total silence and bodily freezing. I was so taken aback by this development that for the first few minutes I mirrored Nathan and also became a statue, but as the minutes progressed, my sense of discomfort grew. I could not understand what was happening to him and where he seemed to have disappeared to, as if Nathan was no longer there, only the shell of his body. Finally, Nathan was able to begin, and when he finished he quipped: *"I seem to have a hard*

time with women". We both laughed at the release in tension. An intelligent man, Nathan reflected on his inability to simply move, and for his final task he painted himself as a stick figure looking, through a microscope larger than himself, at a bundle of his emotions represented by a blue circle filled with red and yellow.

> *Sometimes I lose the microscope just because I'm inundated by everything else. Sometimes it's just overwhelming the… nebulous fear, the nebulous guilt… Sometimes I can force myself into a calm position from an extremely uncalm one…but unfortunately it turns off all emotions. It's like… a numbing position… it's like an emergency switch in my mind that I've somehow either created or discovered, that, you know, you throw in instantly (and) you're completely numb to all emotions.*

It is appealing to shift into medical language here, and label Nathan as having symptoms of catatonia or Clementine as experiencing posttraumatic stress disorder. These explanations are valid. However, beyond the search for deficit and pathology (Davidson et al., 2004), in trying to understand their current situation, the experience of lived time as stuck, stuttering, and stalling translates into a kind of immobility within the everyday. It was necessary for Nathan's older sibling and Clementine's mother to take over decision-making as simple acts of meaningful daily doing could not be willed by them through desire or motivation alone.

8.4.3. *Disconnectedness: "I've always been different"*

Being disconnected from meaningful people or activities, and feeling frozen in time have significant implications for one's occupational identity in the world. A phenomenological understanding of psychosis leads us beyond the medical categories of 'negative symptoms', or rehabilitation terms such as 'lack of motivation', to understand how the very structure of one's experience (as opposed to cognitive skills or emotional reactions) moulds "who one is and wishes to become as an occupational being" (Kielhofner, 2008, p. 106). In the search for meaning, to find words to describe their experience of disconnection, all the participants spoke of consistently having been different in some way. Some spontaneously described themselves as always having been introverted, isolated and prone to living in the imaginary (Naoko, Nathan, Leanne, Tariq and Dinesh). Although, more inclusively, four types of intertwined storylines involved this sense of difference and disconnection: temperament, enduring challenges related to being an immigrant, adverse life events, and/or disruptions due to having a parent with a mental illness.

In the first few minutes after drawing a detailed bird, wings outstretched, waiting to fly, Behgha says: *"Yeah, it's like my life isn't moving forward."* Behgha is the youngest of three in a family raised by a strict father. *"I've always been different"* says the quiet-spoken African youth, *"I guess maybe I'm sensitive in (situations) or… I get my feelings hurt… or care more about what people think than certain other people would"*. He described very few moments of feeling like he fit in, *"I stand out"* because of his incredible lanky height and visible ethnicity, and so *"you have to know what to say in order to do properly"*. Tariq, Dinesh, Priscilla and Mei-Hua also openly referred to ethnic

differences. For them, as for Behgha and Nathan, visible physical and behavioural differences were easier to speak of than the sense of difference rooted in painful childhood experiences at home and at school.

Tariq, Dinesh, Mei-Hua, Clementine and Nathan all spoke of a parent with mental illness who either had to abandon them or had great difficulty in maintaining an emotionally safe home environment. In his current state of significant social and occupational isolation, Tariq refers to relationships as bound to fail: *"love between humans is imperfect, it's incomplete."* Tariq punctuates his floating days of playing the guitar alone at home *"without seeing the hours go by"*, sometimes going to the gym or to a coffee shop, and weekly nocturnal underground parties. He uses drugs to help him overcome his inabilities in experiencing connection to others, and speaks of his metaphysical struggle to connect beyond the surface of things. These participants also avoided connection based on prior relational challenges with parental figures. This was compounded by the fear of becoming like their ill parent. Dinesh fears developing schizophrenia like his father, and ending up like him. *"He works in a restaurant….and doesn't take his medications. He still believes that what he saw in his psychosis was a sign from God…and I also had religious beliefs during my psychosis. He's not the talking type. He doesn't know how to… react really socially… Yeah. As twisted as it may sound, yeah. He's still my father. I still love him."* In searching for meaning, like Dinesh, Tariq, Clementine, Nathan and Mei-Hua speak of their love of their parent, of balancing the fear of becoming like them with images of the parent's resilience and what strengths they might learn from them. Mei-Hua says *"Through that thing [mental illness], I know that my mom is a very strong person. Even as a mom, she can get through all those things. As a child, I will learn from her."*

The experience of disconnectedness that the participants attributed to being different from others didn't stop them from searching for connection with others or activities. Like Clementine, Behgha was applying to attend a new college. Nathan optimistically looked forward to outings with his sibling and writing again. Yet, in spite of this, the long-standing experience of difference made it difficult for these young adults to find a place where they might belong, where they could fit in, where their horizons of meaning are shared with others. From the chronology within their narratives, it seemed as though this disconnectedness bred further disconnection, separation, and immobility, for example Naoko explains that *"one of my roommates, she got a bit scared"* of her and so Naoko withdrew even more.

8.4.4. Where constellations of meaning lie: Clay as acted narrative

The shift from the three paper-pencil drawings that evoke an academic or intellectual task, to clay, a three-dimensional tactile media, fostered a shift in expressive content and evocative process in the participants' relationship to their 'object of desire' (Bruner, 1990). That is, they all created an object that represented what mattered most to them and which, upon exploration, revealed what constitutes the 'ground' of their interest in the world and their 'best good' (Mattingly, 2014; Okumu, 2007). The particularity of the clay task led to an understanding of what I think of as their 'constellations' of meaning, which I define as the meaning they have created from the intertwined clusters of their lived stories from across significant moments and events in their lives. Further, the process of creating this 'object of desire' and narrating the

constellations of meaning around it revealed the participants' ways of engaging in their worlds towards that which matters the most to them. The way each participant's stories related to their manner of creating and the structure of their final clay object revealed an 'acted narrative' (Mattingly, 1998a) about their experience of trying to orient to what is meaningful, yet cannot be reached by them. An experiential narrative has a temporal structure, a before and after of significant events or disruptions, as well as (im)possibilities, and alternate ways that things could have turned out (Bruner, 1986). If experience demands narrative form (Mattingly, 2010a), this form is revealed both in words and in expressive actions. The clay task elicited these particularly meaningful 'could-have-been' representational and gestural narratives.

Mei-Hua quit her graduate schooling as she became more unwell following interpersonal difficulties in her research lab. Throughout the drawing tasks she was folded in on herself, having great difficulty recounting her distress at school, her new dependency on her husband, and her mother coming to Canada to care for her. Yet, when offered the clay, she sat up straight, a smile flitting across her face, and leaned forwards to touch the media with both hands. She quickly nipped some of the clay and began to create a teatime scene composed of a table on which were placed a teacup and saucer, a plate, and a bowl. *"This is a tea table. On it, there's a plate, there's a teapot and a cup, and there's tea inside. And every time we will have tea, we actually will have some… candies here. And some peanuts. And some fruit. So, my family will gather together. In the afternoon, we have afternoon tea. It's… my beautiful memories."* Mei-Hua goes on to speak of her childhood in her family, long before her parent's divorce, her mother's illness, or leaving her native land. Beyond nostalgia for good times, Mei-Hua asserts *"I will go back to my country…to recover…to be where I am respected"*. She desires a return to home, culture, and a sense of relational safety. Yet, the table and tea set that she has created are tiny in microscopic detail. The whole object is barely one inch high and wide. She has placed her finished product at arms length from her, and as she speaks, the three-legged tiny table wobbles and collapses flat. So do her shoulders, as she goes onto explain that her husband has had a job offer in the United States and that they will be moving there as soon as he completes his doctoral degree.

Nathan spent much of his childhood hiding from bullies at school in closed classrooms, as well as hiding in his bedroom closet from his mother's illness episodes. He had retreated into his father's basement at the end of his second year of university. While hiding in dark and closed spaces he discovered a love for outer space, for other possible worlds, which he depicted in his comic books and creative writing. In clay he created a space station, saying,

> *"yeah, that was the initial plan. The plan was to get a PhD in astrophysics and to discover...Well I guess it's supposed to be my dreams right there. I'd love to be in space. I'd love to… I'd love to do a whole bunch of things like that including seeing us get into outer space and being in little spaceships zooming around...But… I don't know, I suppose… I dunno…I… just would have really liked to have… got into physics. I would have really liked to have…. [OT: Gone down that path.]…Yeah. And I doubt I ever will now."*

He has flattened and spread out all of the clay with the fingertips of both hands, creating a hilly surface with depressions on which he has placed two oval balls of clay to represent two shuttles. He too places his object at arms length from him. After saying that he doubts he will ever get to go back to school, he leans back, even further away from the object that represents his desire. Unlike Mei-Hua, there is absolutely no detail in his creation. Without his narrative, there is only an amorphous mound of clay with two more squished blobs on it. It sits on the table, anonymous and unattainable.

Tariq has spoken non-stop throughout his three drawings, trying earnestly to explain his struggle to find love. He has described a childhood of being emotionally neglected by his mother and sexually abused by a family member. He shares just enough to feel understood and then returns to trying to explain his struggle with Satan, his struggle to be good, to stop drugs, to find a good woman, and to overcome the inertia of his days. The clay slows him down. He is quiet for the first time in over an hour. He tentatively touches the clay, and finally tears a chunk into his palm, stands up partway from his chair, leans over the table, and flattens the clay with the whole of his weight into a disk. He adds radial lines around it, and etches in two dots for eyes and a downturned smile. It is a two-dimensional object described as a *"sad sun"*. He leans back – unlike with the drawings, he stays far from this representation. He talks about God, and his desire to find some kind of spiritual peace as well as social accomplishment in his life, such as a job, money, and a wife. He tries to make sense of his inability to find these: *"I know that I am hurting myself staying like this, doing nothing for example all day in my room I do nothing and I know it hurts but God wants this for me, he knows things that I do not understand."* Tariq speaks of being in the shadows, of not knowing how to find his way to receiving the nurturing warmth of the sun. *"The sun it's it's it's me imprisoned seeing things as they appear and not as they actually are and the sun is blinding my eyes and… I think the sun is here and me I look at it and it hurts me."* The sun's rays that he has made lie disjointed and disconnected from the central circle. The downturned smile stares blankly back at us as his voice trails off.

8.5. Discussion

> "Everything has shape, if you look for it. There is no escape from form" (Rushdie, 1981, p. 226)

The use of the Azima Battery - an arts-based, occupational therapy expressive evaluation - facilitated the visual representation and narrative exploration of the lived experience of young adults recently admitted into psychiatric services for a first episode of psychosis. The act of creation, the side-by-side nature of the session, the potential for the expressive object to safely mediate emotional distance as well as open up metaphoric exploration, all contributed to the participants ability to reflect on and verbally articulate what they were experiencing. In addition, this therapeutic mode of evaluation was experienced as engaging by the participants as all nine of them were reluctant to end the session, even after 3-4 hours of interviewing. They all asked, *"can I see you again?"* as well as *"can I come back to visit my pieces and you?"* In this first and only meeting

with this occupational therapist, participants shared difficult topics not previously discussed with their treating team such as ongoing suicidality (Behgha), history of abuse or harassment (Tariq, Mei-Hua, Nathan), and issues around sexual orientation (Priscilla). The use of the Azima Battery facilitated relational and empathic understanding of 'extreme experiences' (Kirmayer, 2008b).

The analytic framework was rooted in the way hermeneutic phenomenology has been taken up in occupational therapy, anthropology, and psychiatry. Such an approach allowed for a deeper comprehension of lived experience of psychosis by entering the language and structure of the world of the individual with psychosis (Doubt, 1994; Lysaker & Lysaker, 2002). In addition, this study contributes to the clinical reasoning of occupational therapists and addresses the stated gap that "[t]he clinical problems that are systematically most difficult for therapists are those that fall within the phenomenological domain, yet these have been given the least amount of attention in the education of therapists" (Mattingly, 1991a, p. 985). The following discussion focuses on the clinical and theoretical implications of the methodology and findings reported herein.

When this approach to hermeneutic phenomenology was applied to observations of activity performance and associated narratives, two key structural elements of the psychotic experience were made visible: A tenuous intentional arc and frozen temporality. These findings are the same as those in studies of the phenomenology of psychosis (Bradfield & Knight, 2008; Lysaker & Lysaker, 2005; Minkowski, 1927; Sass & Parnas, 2001; Urfer, 2001). What this study contributes is the observation of how these structural elements unfold in the process of an expressive activity, and adds to the literature on the use of expressive assessments with individuals admitted to psychiatric services (Heidgerd, 1958/1980). The inability to experience connection to a shared world, or to feel time as a fluid, vital thing, has implications for what kinds of challenges an individual may experience in their day-to-day functioning. Rehabilitation therapists may be tempted to label this experiential state as lack of motivation, or negative symptoms. The participants interviewed herein were motivated: they explicitly spoke of what they desired but varied in how hopeful they were to obtain their goals, as well as more profoundly, their ability to initiate motion towards those goals. For those, such as Leanne and Clementine, who were actively engaged in the world around them, connecting to the experience of success or motion forward was a challenge. Therapeutic approaches that foster a sense of 'mineness' (ipsiety) of self-experience (Parnas, 2000), promote the experience of agency-in-action or connection-to-action (Lysaker, Glynn, Wilkniss, & Silverstein, 2010), or more simply, that facilitate the person with psychosis to experience being the hero of their own story (Davidson, 2003b), should therefore be a focus in rehabilitation interventions

In terms of meaning, the participant narratives moved the understanding of their experiences from one of pathological structure to one embedded in sociocultural trajectories defined by hurt and difference. "Central to the temporal and embodied structure of human experience is the existential fact that we are emplaced in a world" (Desjarlais & Jason Throop, 2011, p. 90), and that the structure of this experience is constituted by a lifeworld. Beyond psychosis as a pathology that distorts the experience of ipseity and self-in-

the-world from within (Parnas, 2000; Raballo & Parnas, 2012), these participants were also survivors of traumatic childhood events such as abuse at home and at school, periods of emotional abandonment by loved ones, and negotiating cultural differences that were described as hostile. These lifeworlds also contributed to a sense of alterity, or otherness, and fed the experience of disconnection from without. These historical life events, the shock of the psychotic episode itself (Shaw, McFarlane, Bookless, & Air, 2002), and ongoing challenges with integrating as visible minorities (Morgan, Charalambides, Hutchinson, & Murray, 2010) were much more than static risk or explanatory factors for psychosis. For these participants these events were very much alive and ongoing. The past, as well as their future hopes and expectations, were wrapped into the 'threefold' present (Ricoeur, 2002).

This has clinical implications for therapeutic strategies beyond the evidence-based medical management of psychosis, as there may be a tendency to reduce and attribute all symptoms to psychosis or schizophrenia, once this illness has been diagnosed. However, based on these participants experiences, it is clear that there may be a need for approaches that safely ask about and address traumatic histories in individuals primarily seen for psychosis (Read, van Os, Morrison, & Ross, 2005). Further, for these participants, who were either first or second generation migrants or had moved to the province from other parts of Canada, these approaches would need to be informed by culturally safe practices to conceptualizing problems and treatment planning (Kirmayer, 2012; Zafran, 2015).

The form and meaning of the participant's experiences was particularly revealed during the clay task. This expressive task has traditionally been 'read' in occupational therapy for its cognitive-organizational (Goodman Evaskus, 1982) or psychodynamic-emotional content (Azima & Azima, 1959). Occupational therapy studies that hone-in on experience reveal that "what may be at stake in both clinical research and translations into practice is…how the terms by which we examine therapeutic practices transform what we are able to see" (Park, 2012, p. S44). Mattingly's empirical and philosophical studies on clinical reasoning in occupational therapy have richly described and explored the use of activity and the therapeutic relationship. Using a narrative phenomenological paradigm, she contends that the creation of a post-facto narrative to coherently describe one's experience of disability or suffering is not the central focus in occupational therapy. Rather, the goal is to understand the actual experience of narrative disruption and to "locate desire" (Mattingly, 1998a, p. 107) in order to drive motion towards meaning again. Further, if experience has narrative form in that it unfolds within an orientation to bodily space, temporality, and relationships, then this experience-as-narrative can be 'read' as dramaturgical action (Mattingly, 2010a). That is, rather than just the cognitive-verbal 'telling-about' experience, when engaged with participants sharing 'with-us' in the present-tense about historically significant events (Mattingly & Lawlor, 2000), their narrative is both told and (en)acted in the unfolding of therapeutic relationship and activity (Fuchs & Jaegher, 2009).

In this study, purposefully expressive activities were offered through the use of an occupational therapy evaluation tool, the Azima Battery. It was during the clay task in particular that significant (or dramatic) experience became the focus of attention for the participant. When the whole of the creation,

actions, and story-telling around the clay task was hermeneutically read as an acted narrative, I was able to grasp and understand the constellations of meaning around the origins of, and what mattered most, to these participants. More deeply, this way of knowing fostered deep understanding of their experience of orienting or engaging with their represented object of desire. This is core to the philosophy and work of occupational therapy. This finding indicates the centrality of the choice of interpretive (or clinical reasoning) framework in terms of what is revealed in the analysis of projective activity performance. Therefore, there are implications for occupational therapy curricula and translation into practice. The hermeneutic phenomenological approach illustrated herein provides empirically driven and philosophically informed concepts for clinical reasoning. This approach to activity analysis needs to be translated and included in the education of occupational therapists as it allows for a deeper way of seeing, and thus evaluating and intervening at the level of lived experience (Mattingly, 1994; Mattingly & Lawlor, 2001).

There are some limitations to this kind of qualitative study. The interpretations proposed herein are a set of possible interpretations; there are other ways of analyzing the data that would lead to different findings. This is inherent to a hermeneutic paradigm, therefore illustrations have been presented with descriptive details for readers to come to their own conclusions, and citations to other studies that have found similar understanding have been provided. In terms of the naturalistic sample, this study was conducted in a city with the third largest foreign-born population in Canada (Statistics Canada, 2006). The findings related to the experience of culture and difference may or may not be similar to other contexts in terms of immigration, youth experience, and local socio-political climates (Das-Munshi et al., 2012).

Future research to further develop the narrative reasoning (Mattingly, 1998b) of occupational therapists using expressive assessments with youth seeking help for psychosis should focus on translating how to elicit and listen for both narrative disruptions as well as constellations of meaning. This is of import both for currently practicing clinicians as well as occupational therapy curricula. The link to intervention could then become one of therapeutically plotting meaningful experiences (Mattingly, 1994), that can provide possible narratives. If psychosis is about disconnect, then eliciting and attending to the (micro)moments when the person's intentionality is tethered to a meaningful phrase, mood, activity, or person, can help to tailor interventions that focus on doing and belonging (Hammell, 2013), within an orientation towards the future, as well as a healing of the past (Whitley, 2010).

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Table 8.1: Participant pseudonyms and brief description of their self-reported significant life experiences

Pseudonym	Brief Identifier	Occupational Status	Significant Life Events
Naoko	20 y.o. woman, immigrant from E. Asia	International student, living in a dorm, and enrolled in first year university. Financially supported by her parents	Only child, moving across the world on her own to study was the biggest transition she had ever experienced. She developed a strong Christian faith in the weeks prior to being interviewed
Behgha	18 y.o. male, immigrant from war in Central Africa	Living at home, stopped college. Is now applying to new school programs, volunteers at the SPCA*. Comes from a well to-do family	Youngest of three, raised by a father who believes in physical discipline and punishment. Behgha had attempted suicide which is what brought him to psychiatric services
Clementine	18 y.o. female, parents immigrated from South America	Living at home, had stopped college and part-time work at a fast-food restaurant. Just started college courses again. Financially supported by her father	Her parents divorced when she was 8 years old due to her mother's mental illness. She and her older sibling were raised by her father in a poor neighborhood
Dinesh	21 y.o. male, immigrant from SE Asia	Living at home, stopped university. Currently not engaged in any meaningful activities. Family lives close to the margins of poverty. Considering applying for welfare	Father diagnosed with schizophrenia and has always refused treatment. Parents remain together. Has one sister. They grew up on the margins of poverty. Dinesh broke up with his first serious girlfriend as he began to feel unwell
Tariq	28 y.o male, immigrant from NE Africa	Living on his own, goes to nightclubs and the gym. Spends his days alone. Lives on welfare with his older sister helping him financially at times	Was given by his mother to his aunt when he was a child. He was raised with his cousins with sporadic contact with his mother and sisters. Sexually abused by a caregiver. Moved to Canada to study and escape civil turmoil. His mother died soon after he left
Nathan	24 y.o. male, moved from W. Canada	Was living in his father's basement for two years after stopping university. Moved into an apartment in the same building as his sibling a few months ago. Just starting to socialize again. On welfare	When he was 5 and his siblings were 9 and 10, his father worked up north and developed cancer within the same time period as his mother developing a mental illness. Was severely bullied at school through his elementary studies. His sibling pulling him out of the basement and bringing him to live near her facilitated his entry into treatment
Mei-Hua	25 y.o. female, immigrant from E. Asia	Lives with, and financially supported by, her husband. Stopped her doctoral studies. Currently attending a mental health day program	Her father had an affair and left her mother when Mei-Hua was 13 years old. Her mother fell into an irritable depression for almost two years. There has been minimal contact with her father since then. She learned another language and obtained a full doctoral scholarship to move to Canada. Upon starting her graduate degree she experienced workplace harassment in her research unit while simultaneously planning her wedding
Leanne	24 y.o. female, moved from E. Canada	Lives on her own, successfully completing a graduate degree. Financially independent with graduate bursaries and funding	Is the younger of two from a family that is described as solid and quiet. Left her longtime boyfriend to move for her graduate studies. Killed her pet at the onset of her psychotic episode
Priscilla	18 y.o. female, parents immigrated from E. Asia	Lives at home, helps out in her parents' corner store, stopped college.	Has an older sibling diagnosed with a serious learning disability. Experienced significant online bullying in high school when she expressed her attraction to her same-sex friend

*SPCA: Society for the Prevention of Cruelty to Animals

Chapter Nine: Integrative synthesis and implications

"To understand just one life, you have to swallow the world"
(Rushdie, 1981, p. 109)

"The complexity, difficulty and challenge of elegant occupational therapy practice are *hidden in the mind* of the occupational therapist"
(Wilding & Whiteford, 2007, p. 191)

The use of activity-based evaluations to aid in mental health case formulation and intervention planning has long been a core aim and disciplinary specialty in psychiatric occupational therapy (Fidler & Fidler, 1954). When these activities are expressive or projective the individual is offered an evaluative approach where he or she can reveal their current mode of being in art media, thus showing what he or she may not always be able to tell. The opportunity to phenomenologically understand an adolescent or young adult's mode-of-being through expressive telling and doing, as well as exploring what matters to them, is in line with recovery-oriented care. The occupational therapist's skill in administering such evaluations includes the ability to build therapeutic rapport, ask open-ended questions, and genuinely explore the narratives and expressive actions that are elicited in such evaluation approaches. Further, observing and interpreting the whole of a projective session, with the ensuing clinical case formulation, requires a reflexive attention to the interpretive traditions and frameworks at play.

In this chapter, a brief summary of this dissertation is provided for ease of readership. The main discussion points and implications are revisited. This is followed by an exposé of further findings from within and between the methods. This is done to support an overarching layer of integrative analysis and implications of this series of studies as a whole. This mixed methods study was conceptualized within a hermeneutic paradigm. As such, it highlights not just the results of each method, but also the experience of conducting the research as well as the tensions and questions raised between the methods and results. In particular, as the study progressed, reflexive attention to articulating pre-understanding, empathic orientation towards the participants, as well as my widening of horizons of meaning in relation to the domain of inquiry were central to the shape and foci of this thesis (Van Ness et al., 2011). This final chapter offers an integrative synthesis of the doctoral project supported by findings from the entire series of methods in order to outline the clinical and theoretical implications, the original contribution, strengths and limitations, and avenues for future research.

9.1. Summary of dissertation

This thesis began with a personal reflection on my adolescent story of war-driven immigration. I shared how impossible it was back then to articulate my splintered experience in words. Painting helped me both to tell metaphorically and representationally of my needs and desire, as well as to therapeutically calm and center me. This personal story was then linked in the first chapter to the clinical challenge of diagnosis in

first episode psychosis, and the problems that youth with mental health issues may have in articulating and naming their experience. Mental health evaluation processes were problematized in two ways: (i) the first being how we allow patients to reveal themselves, shifting from the primacy of verbal interviews to postulating the utility of an expressive arts-based occupational therapy assessment process; and (ii) to shift from the objectivist idea of evaluation as 'reading' for illness to an intersubjective stance that acknowledges the skill and interpretive framework of the evaluator as well as the positionality and context of the patient.

The second chapter provided a review of the literature to contextualize evaluation practices in early psychosis programs within current policy and evidence. A biomedical approach to detecting and diagnosing psychosis and eventual schizophrenia was contrasted with the literature on phenomenological psychopathology and early psychosis. Phenomenological paradigms were demonstrated to be more valid in detecting long-term schizophrenia, as well as ethically resituating personhood at the center of the clinical case formulation. Yet, the challenges of verbal interviewing in youth mental health remained acknowledged. Thus, the contribution of an occupational therapy activity-based projective evaluation was introduced and proposed. The Azima Battery was designed specifically for use to aid in mental health case formulation and foster communication with individuals experiencing psychosis. Pilot data for the predictive validity of the Azima Battery was presented in Chapter Two, as well as a clinical narrative, to support the rationale for this doctoral study.

The aim of this research was to investigate the criterion validity of, and explore and illustrate a phenomenological approach to, the case formulation and process of the Azima Battery with youth aged 15-35 deemed to be experiencing the range of pre-psychotic to early in their first episode of psychosis. This was in order to better understand the experiences of help-seeking youth, and to aid in the detection of incipient schizophrenia, through the use of an activity-based clinical assessment that is setup in a consistent manner with all participants. A hermeneutic mixed methods study design was described in Chapter Four. This interpretive paradigm was chosen because (i) it aligned ethically and epistemologically with the Azima Battery, (ii) it promoted reflexive attention to the interpretive traditions inherent in the Azima Battery case formulation and clinical reasoning process, and (iii) it fostered an ontology of the in-between in order to integrate findings from across methods.

In order to situate the development and interpretive tradition of projective assessments, Chapter Five took the reader through a critical retracing of the historical roots and scientific evidence for occupational therapy projective evaluations. The underlying theoretical issues emerging from the psychodynamic roots of projective assessments were reviewed. Then, the sociopolitical undercurrents and shifts in psychiatric discourse surrounding the development, rise, and fall of these assessments within North American occupational therapy were outlined. A scoping review of the published evidence to date was presented as mirroring this rise and fall. A critical appraisal of both history and evidence highlighted the need to shift from a purely quantitative approach to one that acknowledged the relational core of projective evaluations, and that

research needed to also explore the clinical reasoning of experts who currently use such evaluations in their occupational therapy practice.

This was followed in Chapter Six by a qualitative study that elicited and explored the experiences and opinions of nine experts in this domain of practice. The findings outlined the lived history of developing and using expressive assessments, the challenge of maintaining this form of evaluative practice, perspectives on how to administer, interpret, and teach the unfolding of a projective evaluation session from an occupational therapy orientation, and expert opinions on their ongoing clinical utility. Chapter Six ended with epistemological clarity about the tensions between the diagnostic and therapeutic aims of projective evaluations. Guidelines for clinical education and use were provided, and future research avenues suggested. Through this process, an argument was clearly made for the particular relevance and clinical utility of occupational therapy projective assessments in youth mental health, for both diagnostic case formulation and therapeutic-evaluative purposes.

In terms of the validity of case formulation, a quantitative study describing the one-year predictive validity of the Azima Battery is found in Chapter Seven. The ability of the clinical impression of the Azima Battery to detect a future diagnosis of schizophrenia was calculated in comparison to the psychiatrist's initial impression, in a sample of 62 individuals followed in early psychosis intervention programs. The positive predictive value of the Azima Battery outperformed that of the psychiatrist's initial diagnostic interview (94% vs. 48%). In addition to the different epistemological frame for case formulation (i.e. phenomenological vs. biomedical), the Azima Battery offers the opportunity to observe patterns of performance on projective tasks. Therefore, a sequential exploratory mixed method phenomenological analysis was conducted to examine the patterns of projective performance most distinctive for a future diagnosis of schizophrenia. The results demonstrated that the combination of variables that describe the structure of task performance were most distinctive for those eventually diagnosed with schizophrenia. This chapter concluded that the Azima Battery is a valid complement to psychiatric diagnostic interviewing to more accurately detect incipient schizophrenia in youth seeking help within early psychosis intervention services. The structure of projective performance is key for case formulation with individuals potentially experiencing incipient schizophrenia. However, it is not a combination of exact prescriptive signs within the structure of activity performance that accounts for the predictive ability of the Azima Battery. Rather, the results highlighted the importance of further exploring the interpretive clinical reasoning involved in the whole projective session.

Finally, Chapter Eight introduced a hermeneutic phenomenological approach to interpreting the unfolding of the Azima Battery evaluation with nine youth recently admitted to an early psychosis program. The findings illustrate an in-depth understanding of the structure and meaning of these participants' experiences, as elicited in their narratives, actions and created objects. In terms of structure, the participant's tenuous ability to connect their inner experiences to the outer world was described as a wavering intentionality. The difficulty in consistently connecting to a shared world of meaningful doing was coupled with the experience of lived time as stuck, or frozen. This led to an inability to either act on desires, or to

experience the sense of motion forwards even when actively engaged. Clinical ideographic illustrations of the observations that led to these interpretations were provided. In terms of meaning, the participants all shared their experiences of difference beyond internal pathology as related to being thrown into externally adverse events such as difficult migration experiences, harassment, workplace abuse, childhood abuse, and other traumas. In particular, several of the participants experienced a combination of these events in the context of having a parent with a mental illness. The potential of clay to elicit a core acted narrative from the participants was discussed. All the participants created a meaningful object of desire in clay, yet their narrative and gestural accompaniments to this object revealed the experience of not being able to engage with what matters to them. The chapter ended with the clinical and educational implications of the findings.

The following discussion picks up where these chapters left off. The upcoming sections elaborate on and emphasize some of the findings in the summarized chapters by linking results across methods. Further, an attempt is made to make visible what is implied between the methods and in the translation to clinical practice.

9.2. Who seeks help for early psychosis?

The risk of developing psychosis is greater in immigrant youth who live in areas that are experienced as unwelcoming (Das-Munshi et al., 2012; Morgan et al., 2010). As well, urbanicity, socioeconomic status, and personal adjustment to life events all increase the risk for transition to psychosis in UHR youth (Dragt et al., 2011). Therefore, in addition to a mental illness, the early psychosis population is likely to already be a socially marginalized, voiceless, or disempowered group. In spite of the prevalence of the stress-vulnerability theory (Nuechterlein & Dawson, 1984), elite early psychosis intervention programs prioritize biomedical-disease assumptions of illness causality and presentation (e.g. EPPIC, 1988-2014; PEPP, 2014). Yet, the question of migration, identity, and psychosis is an unavoidable aspect of working in a city with the third largest foreign born population in Canada (Statistics Canada, 2006). In this study, only 18% of the total quantitative sample (N=62) was identified as being from this province, and 6% were more than third-generation Canadian who had moved to Quebec. The remainder of the sample had parents born outside of Canada (14%) and the majority of the youth sampled from an early psychosis intervention clinic between 1997-2013 were themselves first-generation migrants (57%). This stands in contrast to phenomenological psychopathology studies in continental Europe where the reported samples are either culturally quite homogeneous or where migration or ethnic status are not noted (e.g. Møller, 2001; Parnas et al., 2003; Schultze-Lutter et al., 2007). This raises a cautionary note about the cross-cultural interpretation of phenomenological psychopathology studies.

Further, 46% of the total sample (N=62) had a known family psychiatric history, 60% reported adverse life events during childhood, and 29% of the total sample had both a family psychiatric history and had experienced adverse childhood events. The data herein does not allow for the examination of correlation or causality between all these elements-as-risk factors. However, the qualitative analyses with nine participants

highlighted how the sociocultural and relational experience of trauma and difference was inextricable from the pathology of disconnection from a shared world. There is a need to view these 'risk factors' as dynamically unfolding in the present moment, and as having ongoing lived concern to the participants. It is worth noting that when culling through the medical records of all 62 individuals followed in early psychosis, family psychiatric history was certainly noted in the initial psychiatric reports, but migration status and trauma histories were inconsistently reported, or else relegated to a listing of risk factors. It was primarily in the occupational therapy projective reports that the details and effects of trauma, migration and family difficulties were interpreted and related to current presentation and case formulation. More importantly, in spite of the presence of adverse childhood trauma, only six of the 62 individuals received therapy specifically tailored to their trauma experience.

The clinical implications are evident; particularly in an era of recovery oriented care that emphasizes the individualization of care and the importance of culturally safe evaluations and interventions. Early psychosis evaluation can, and should, incorporate the research conducted for the DSM-5 on culturally informed case formulations (American Psychiatric Association, 2013). Studies have shown that incorporating sociocultural information in mental health evaluation encounters promotes client engagement in diverse populations (Alegria et al., 2012), as well as refining diagnostic accuracy in early psychosis case formulation (Adeponle, Thombs, Groleau, Jarvis, & Kirmayer, 2012). What this doctoral study has demonstrated is that the Azima Battery is both a valid and relationally safe complement to diagnostic interviewing for culturally informed clinical case formulation. The safety experienced by participants was evidenced by the extent of engagement and sharing during the evaluation. Early psychosis teams need to act on these case formulations and tailor evidence-based approaches to trauma, and advocacy focused rehabilitation, for the relevant subgroup of individuals.

9.3. Epistemology of evaluation

It is clear that a phenomenological paradigm that focuses on eliciting and analyzing the gestalt of the structure of a youth's experience is a more valid approach to conceptualizing early psychosis and detecting eventual schizophrenia. Further, the space allowed to understand how the individual attributes meaning to, and makes sense of, their unfolding life story is key to person-centered care. Chapters Five and Six traced the tensions between the diagnostic and therapeutic functions of occupational therapy projective assessments. Yet, it is precisely within the tension between the deductive-causation reasoning of diagnosis and the interpretive-discernment of the particularities of lived experience that clinical utility emerges. Karl Jaspers was a pivotal figure in phenomenological psychopathology. He, like many others, made the distinction between epistemologies and methods for the understanding (verstehen) of experiences from within, and approaches used to explain (erklären) and establish causal connections from without. He goes further, towards synthesis, and states: "In questionable cases where one or the other expression could be used interchangeably we shall

use the term *'comprehend'* (Begreifen)" (Jaspers, 1959/63, p. 28). The etymology of the term comprehend is 'to unite, to seize completely' (Harper, 2001-2014).

Adopting a second-person perspective within a phenomenological paradigm fosters this comprehension. A third-person perspective assumes neutrality or objectivity, in line with a quantitative positivist stance. The first-person perspective focuses on an individual's subjectivity, which is arguably an unattainable point of view for knowledge creation that involves a relationship (in research or clinical practices). The second-person perspective involves an intersubjective stance whereby both parties engage in bridging across horizons of meaning (Kirmayer, 2008b; Stanghellini, 2010), or in crossing sociocultural borders (Mattingly, 2010b). From the perspective of philosophical hermeneutics, transcendence – or moving past the limits of current understanding - occurs when horizons of meaning have been stretched or fused between two people (Davey, 2006). The Azima Battery evaluation process promotes the possibility of the second person mode of understanding because of its multi-modal setup, the reflexive shifting between different forms of clinical reasoning, and the phenomenological approach to therapeutic interviewing. The distinctions between neutral objectivity in evaluation or the artificial sole focus on a first-person narrative ignore the interpersonal context of eliciting a story as one of an inter-view, the sharing of views (or horizons) between two people (Kvale & Brinkmann, 2009). These perspectival issues speak to the flaws inherent in the "uncoupling of assessment procedures and therapy… in clinical psychiatry" (Stanghellini, 2007, p. 69).

Chapter Six of this thesis argued for the centrality of complex narrative reasoning in occupational therapy, and the ability of such reasoning to holistically bridge the artificial divide between fact-finding and therapeutic understanding in evaluations (Finn & Tonsager, 1997). This leads to comprehension of the individual. To support this statement, the following is summarized from my field notes during the data collection that took place over the summer of 2013 for the quantitative portion of the study. It is commonplace practice at the study site to tag useful parts of the medical record with a post-it note. For example, tagging an in-depth neuropsychological report, or a well-written and typed up diagnostic interview by a psychiatric resident who had the time to do so early in their clinical rotation. In 42 of the 62 (68%) medical records, the Azima Battery projective report was one of the two-three tagged sheets in an individual's chart, revealing it's utility in everyday clinical practice. In qualitatively examining why the projective reports had been tagged, the following elements were only found in the occupational therapy report, or else were charted months or years later in the individual's medical record:

- Details of childhood trauma
- The experience of self as migrant and the inclusion of sociocultural aspects as part of the case formulation
- Exploration of sexual intimacy, sexual experiences, and/or sexual identity
- Neuropsychiatric problems such as cognitive or learning disabilities

- The embodied experience of self in response to weight changes and side effects of medications. (The presence of these were noted in nursing notes, but not explored in terms of the individual's lived response to them.)
- Existential concerns about what is meaningful to them, the experience-near understanding of embodied metaphors such as *"I'm fraying at the edges"* or *"balancing myself between good and evil"* that are not simply relegated to symptomatology, worries about 'growing up' and becoming an adult, and the experience of becoming a "patient"

With respect to the last point, only one of 62 medical records contained a non-occupational therapy case formulation by a nurse-psychotherapist that explicitly took into account how becoming a patient was affecting a young woman's presentation and actions as a patient. Thus, the clinical utility of the Azima Battery as a phenomenological and activity-based mode of evaluation is that it reveals how the person experiences their pathology within their worlds (the who), as well as revealing the pathology itself (the what). This leads to a case formulation that promotes a more holistic comprehension, which is in line with recovery-oriented care. As Clementine said upon ending the session *"well, that was cool, we covered much more stuff than with the psychiatrist…can we do this again?"*

9.4. Ontology of psychosis, or, what is psychosis?

Phenomenological psychopathology has argued for a changing epistemology of how it is we come to know the entity called 'psychosis' by shifting from a biomedical search for discrete symptoms, to deeply understanding the individuals structure, or mode-of-being in the world (Parnas, Sass, & Zahavi, 2011) This doctoral study supports this argument by providing quantitative evidence for the predictive validity of the Azima Battery in accurately diagnosing incipient schizophrenia, as one instantiation of this epistemological shift. In addition to the importance of the accuracy of diagnostic case formulation is the potential to improve person-centered care. Listening with a different ear, such as in hermeneutic phenomenology, coupled with expressive activity, allows for the creation of therapeutic rapport, and a deeper understanding of the way that the person meaningfully orients to their experience, in order to tailor treatment to the individual in their life situation (Katz & Shotter, 1996; Stanghellini, 2007).

I would like to take the argument further, as shifting the epistemology of evaluation towards the second person perspective also raises questions about the ontology of psychosis. That is, what is the nature of psychosis, and more importantly, how does it emerge, and how is it recognized in the clinical encounter? I raise this query based on the reflection that the 'schizophrenia' recognized within the context of the Azima Battery is not necessarily the same as that within the psychiatrist's initial diagnostic interview, and yet it is the schizophrenia that has unfolded and is diagnosed a year later. How we allow our clients to speak or show of themselves necessarily refashions what it is we see and understand to be psychosis, since this form of attentive listening "rescue[s] abnormal fringe phenomena that are not usually covered by standard assessment procedures" (Stanghellini, 2007, p. 70).

The phenomenological description and interpretation of the projective evaluation sessions as well as statistical analysis of the patterns of expressive performance did not highlight the features currently thought to be most salient for a biomedical diagnosis of schizophrenia. That is, hallucinatory or delusional content (also known as positive symptoms) did not emerge as significant in either the quantitative or qualitative arms of this research project. The negative symptoms of schizophrenia –such as lack of motivation or interest, alogia, or flat affect – have been said to be core to a future diagnosis of schizophrenia (Rapado-Castro et al., 2010). Yet, this finding was contradicted or re-understood in a more nuanced fashion in this project. The nine participants interviewed herein all spoke and represented clearly their object(s) of desires and what matters to them, therefore none of them presented with avolition. The expressive process also allowed for the exposition of alogia (loss of a coherent thought process) as observed in the phenomenological description of the disorganized creation of art objects, and which was significantly correlated with a final outcome of schizophrenia in the quantitative arm. However, the arts-based tasks also permitted the circumvention of this disorganization as the expressive process provided the participants with the opportunity to communicate their experience clearly beyond the use of words, in gestural actions and representations in expressive media. Finally, none of the nine participants presented with flat affect. They all spoke and shared with emotion, particularly in relation to sad moods, as well as flickers of hope now that they were in treatment. The centrality of the presence and affective quality of mood in incipient vs. long-term schizophrenia has been noted as an important diagnostic marker (Schultze-Lutter et al., 2007).

The structural features of the experience of psychosis, as explored and examined in this study sample, were either not the ones found in the DSM-5, or lent a more profound conceptualization to 'catatonia' or 'disorganization' as the experience of frozen temporality or of fragmentation (Saks, 2007). Thus, this shifts the list of symptoms for schizophrenia in the DSM-5 to one of a list of epiphenomena that arise from a core disturbance of the experience of 'self' (Nelson et al., 2008). Yet, even then, care must also be taken not to simply locate the origin of this self-disturbance within reductive neurobiological models of selfhood, but rather, to also take into account how the social and the cultural get taken up in our understandings of illness (Choudhury, 2009). As well, how our experience within our life worlds (of trauma, migration, parental illness) may become written onto our brains, and vice-versa, unfold in a given set of circumstances (Choudhury & Slaby, 2012).

9.5. Mode of evaluation: A classical occupational therapy approach to activity analysis

This project has provided evidence for the validity of the Azima Battery in mental health case formulation with this population, as well as its acceptability and engaging nature. Nonetheless, some critical notes are warranted. While a standard setup facilitates validation processes as well as an occupational therapist's learning curve, it could be disputed that for true recovery-oriented care a choice of expressive media could be offered in order to "use assessment to develop and validate personal meaning" (Slade, 2009, p. 12). In particular, perhaps media that would be considered more contemporary such as variations on

graffiti paint, installation art, or collage. It is important to note that an increase in choice of media offered improves the validity of case formulations (Hammer, 1981). Further, many different expressive assessments exist in occupational therapy that were created for differing purposes with variations in observational and interpretive foci or frameworks (Hemphill, 1982a). Each proposed assessment or series of media would have to be validated for its stated clinical purpose. The historical, theoretical, and disciplinary roots of the Azima Battery make it a unique intake evaluation tool for use with an early psychosis clientele.

In terms of structure and process of performance, all the tasks in the Azima Battery revealed elements of the participant's mode-of-being with psychosis. However, the demand of clay to be involved beyond fingertips of the dominant hand in drawing, as well as its affordance for motion and three-dimensionality, led to the emergence of a core acted narrative for each of the nine participants. If occupational therapy is concerned with meaningful doing, then a media that can tap into the experience of how the person orients to what is most meaningful to them is necessary. Interestingly, the original sequence of the Azima Battery began with clay and fingerpaint, and ended with drawings (Cramer-Azima, 2012). This followed the psychodynamic assumptions of 'regressive' media that then shifted into more 'contained' or adult media. However, upon use, the sequence was altered to begin with drawings and end with clay and finger paint (Cramer-Azima, 1982). This was for several occupational therapy-informed reasons: (1) To begin with a familiar and less threatening media (paper-pencil), (2) to work up towards clay and finger paint, and therefore to (3) to observe the progression of performance from more to less familiar tasks as well as the individual's response to a progression from more to less structure across the five tasks.

In terms of content, the paper-pencil tasks in the Azima Battery elicited more cognitive responses, being a familiar media associated with study and work. In the qualitative portion of this project the content of the drawing tasks revealed the more factual as well as negative aspects of the participant's experiences that were easier to talk about, such as being hospitalized, dates of events, current living situation etc. The shift to tactile, three-dimensional clay and colorful fingerpaint opened up content about hopes, dreams and desires. The quality of engagement as well as projective responses of an individual to the different media allows the tailoring of further intervention planning that may focus on the use of expressive media to foster the expression and development of a more hopeful personal narrative and positive sense of identity (Leamy et al., 2011).

The final fingerpaint, while remaining tactile and offering colors, returned the participant to two-dimensional creation. In this qualitative study the fingerpaint seemed to either elicit an image of the continuation of the theme of the object of desire elicited in clay (Mei-Hua), coping with the inability to have this object through escape (Leanne, Tariq, Nathan, Priscilla, Behgha), or an idiosyncratic representation of inner fragmentation (Naoko, Clementine, Dinesh). It would seem then, that indeed the sequence and the ending tone of the evaluation session may also be of significance (Azima & Azima, 1959). In the follow-up data obtained from their medical records, Mei-Hua did indeed return to her homeland three months after the research session, thus obtaining what she desired most. For those who ended the session on a note of

'escape', the stories are equally interesting. Leanne completed her university degree that semester, and continued to be seen for therapy related to anxiety in leaving her home. Tariq was lost to follow-up a few months following the research session. Nathan was unable to improve his community integration, in spite of assertive interventions he remained primarily holed up in his apartment, unable to move out into the world. Behgha, against his father's wishes and with his mother's help, moved to a college in another province. Priscilla returned to school but with ongoing significant social challenges, she remained on the periphery. As for the latter three who represented fragmented images in their final fingerpaint, all three continued to experience significant psychiatric symptomatology and medical instability for several months after the research evaluation.

9.6. Occupational therapy clinical reasoning and the speculative nature of activity performance

In this study, I used both a descriptive phenomenological approach to examine patterns of performance as well as a hermeneutic phenomenological paradigm to interpret what emerged between occupational therapist and participant, participant and process of creation as well as created object, and my own response as interviewer to the creations. That is, an interpretation of the 'how' of emergence. Phenomenological approaches to interpretation in clinical contexts are not only important for qualitative research about the lived experience of health care conditions (Mattingly & Lawlor, 2000), or to further theorizing about human occupation (Park Lala & Kinsella, 2011b), phenomenology can also further the articulation of occupational therapy clinical reasoning. One of the objectives in this thesis was to explore and illustrate an interpretive (or hermeneutic) phenomenological approach to the analysis of an expressive projective evaluation session. The findings in Chapter Eight speak to the utility of such a methodology not just in research, but also as a form of clinical reasoning in its own right, to deeply understand a given person's experience and, therefore, tailor intervention. Thus, thinking interpretively or hermeneutically is a skill that could be fostered for clinical practice and not just research applications. This is supported by empirical and theoretical work on the variety of forms of expert clinical reasoning that are interpretive rather than deductive in nature, and links back to the early study in projective assessments whereby 'intuitive' evaluators were more accurate in their case formulations than 'cognitive-deductive' ones (Schmidt & McGowan, 1959).

In contemporary critical work on clinical reasoning, clinical 'intuition' is framed within a phenomenological paradigm, whereby the tacit and embodied knowledge (or praxis) of an expert has widened their capacity to 'grasp' the whole pattern rapidly (Braude, 2013). Clinical reasoning in occupational therapy has also been examined at the intersection of phenomenology and anthropology (Mattingly, 2010a). This allowed the conceptualization and articulation of the skills involved in 'narrative reasoning' that are honed to understand the motives and dreams of individuals and their families within their sociocultural and health care situations (Mattingly, 1998b). These interpretive forms of clinical reasoning sustain an 'art of practice' focused on the relational, the contextual, and on the experience of what may be meaningful (Peloquin, 1989; Weinstein, 1998).

Philosophical hermeneutics speaks of the 'speculative' nature of interpretive understanding (Davey, 2006), and, therefore, the risky nature of interpreting expressive activity. The disempowering effect, for example, of psychoanalytic psychodynamic interpretations of projective assessments was described in Chapters Five and Six. The qualitative hermeneutic finding about the expressive utility of clay stands in contrast to the quantitative finding that perceptual difficulties in the structure of the clay may be distinctive for a final diagnosis of schizophrenia, as well as other psychodynamic studies that note the failure of individuals with schizophrenia to be able to work at first in clay (Foster, 1997). Yet, as one former teacher, Sandra Everitt, always said: *"OT is not about what you do, it's a way of seeing"*, in other words, it is the ability to see the invisible in multiple ways. This indicates the centrality of reflexivity, defined as the active interrogation of interpretive systems, as a skill for clinicians (McCorquodale & Kinsella, 2015; Phelan, 2011), and not just for qualitative researchers (Finlay, 2008).

Projective activity performance is a form of speculative language that can be read hermeneutically; that is, it opens up meanings and the possibility for empathic understanding, as well as interpretive conflicts and the possibility for misunderstanding (Ricoeur, 1974). Occupational therapy and occupational science can certainly benefit from phenomenology and hermeneutics as a way of seeing and understanding the orientation of meaning doing, being, becoming and belonging for a particular individual (Fidler & Fidler, 1978; Hammell, 2013; Park Lala & Kinsella, 2011b; Wilcock, 1998). This is especially so if as one expert is quoted as saying in Chapter Six, there still isn't a *"shared language*" for occupational therapy projective assessments. As this study progressed, I became more attuned to the various ways in which we search for and categorize an experience as 'psychotic' from medical, phenomenological, and occupational dysfunction perspectives. Different templates for deductively analyzing occupational performance, such as checklists of dimensions of activity analysis, do point towards dysfunction. But, they also foreclose – or need to be balanced with – attention to the particularities of lived experience. These are two different modes of reasoning (Bruner, 1986). As a therapist, I was concerned with the following: The intentional arc is defined as both (1) an orientation towards a specific meaningful constellation of being-doing beyond the confines of one's interior landscape or 'inscape' (Lanham, 2002), and (2) as the ability to connect to this constellation in a shared world. Therefore, I needed to be able to look for the moments and ways in which a person is called-forth beyond themselves, otherwise I would be reifying the construct, and individual's experience, of psychosis-as-disconnection. I needed to be able to see when they are able to connect, to what, and how. That is, their own particular *becoming* or ontological moments of emergence. In the Azima Battery, the participants particularly revealed this during the clay task.

Interpretively reading the unfolding of the clay creations as an acted narrative hermeneutically tied the parts of the qualitative data into an overall whole whereby what was at stake for the participants, and their (failed) experience of engaging with what was meaningful to them, emerged as a dynamic visual and enacted metaphor. Priscilla very hesitantly spoke of her struggling with her sexual orientation, her parents' over-protective Asian values and their need for her to succeed if her older brother could not, as well as being

bullied at school. In clay she assembled the parts of an androgynous person, barely held together, who could not stand up after several tries. Certainly, one could critique her organizational and problem-solving skills from one perspective. She then tried to have the figure sit. It still wouldn't hold up. So, she leaned the figure against the remaining large lump of clay. The figure sat, slumped forward, head lolling threatening to fall off. Arms and legs akimbo, exactly like an unused or string-less puppet figure. Priscilla spoke of trying to go outside (walk) into the world, and see friends, but that she wasn't able to do this without support.

In his works of fiction, Rushdie returns over and over to the experience of migration and identity. He locates psychosis, or fragmentation from the world and meaning, both within his characters as well as in their worlds. In his literary explorations, he contends that "reality can have metaphorical content; that does not make it less real" (Rushdie, 1981, p. 200). Metaphor is the shift from the literal to the figurative, where newly invented metaphors stand as figures, or mini-stories, that invite the exploration of meaning (Ricoeur, 1977). Johnson links the use of metaphor in language to bodily experience that gives rise to these figures, that these metaphors "contribute to the process by which our experience and our understanding (as our way of 'having a world') are structured in a coherent and meaningful fashion" (Johnson, 1987, p. 98). Jackson also argues for the embodied character of metaphorical expression and asserts that metaphor reveals the social and practical experience of doing-in-the-world (Jackson, 1983). In illness and suffering, individuals resort to culturally-mediated bodily metaphors to express and shape their experiences (Kirmayer, 2008a). In occupational therapy, listening to metaphor in clinical interviews (Helfrich et al., 1994), and observing activity-as-embodied metaphor (Park, 2012), offers an avenue to deepen the understanding of a person's orientation to and healing in the world. In this study, the clay object represented what was desired while the expressive process revealed a figurative way of understanding the experience of not being able to engage with this desire. Metaphor theory - and here I am including visual metaphors in created art objects, and acted narratives that can be read as enacted metaphors - thus has the potential to add understanding to the 'speculative' (Davey, 2006) and layered nature of expressive activity performance using clay. This is especially salient when the associated story telling is about the liminality of illness (Jackson, 2009), in between a place of wellness and the uncertainty of the future (Kirmayer, 1992; Mattingly, 2010a), where words to describe experience, and even more so, to "locate desire" (Mattingly, 1998a, p. 107) may not be so easy to find.

9.7. Critique of the research project: Limitations

Due to the inextricable nature of the "interpreter-with-[her]-test" (MacFarlane & Tuddenham, 1951, p. 51) of projective assessments, this study only examined the processes and outcomes of the naturalistic use of the Azima Battery by one occupational therapist, this doctoral candidate. This was for both the qualitative and quantitative portions of the project, as I had been the clinician who evaluated the whole retrospective sample with the Azima Battery during my tenure at the MUHC's Early Psychosis Intervention Centre between 2004-2011. Thus, this study highlights my expertise and interpretive framework as opposed to a more generalizable attempt at validation. This was echoed in the interviews of experts in Chapter Six whereby

each expert described a different approach to the interpretation of a projective profile. That being said, this project also emphasizes the need to examine such intersubjective processes and the clinical reasoning that underpins activity-based evaluations. The articulation here of the validity and clinical utility of one expressive assessment in youth mental health can also be seen as an exemplar of making visible the 'underground practice' of occupational therapists (Mattingly, 1998b).

The naturalistic comparison between the Azima Battery case formulation and the psychiatrist's initial diagnostic impression may be criticized as not meeting a gold standard for establishing psychometric validity of a health measurement tool (Streiner & Norman, 2008). This may certainly be true particularly since different attending psychiatrists, who each may approach their practice from various expert and interpretive frameworks, posed the initial psychiatric diagnosis in this study. Further, several psychiatrists may have evaluated the help-seeking youth upon his or her entry into psychiatric services. This was addressed in the data collection process by retaining the diagnostic impression that was posed closest in time to the date of the Azima Battery session, and in the same service setting. The modal time between the two compared assessments was one week. While understanding a given psychiatrist's own interpretive framework is just as important as that of the occupational therapist in her case formulations, this project offers ecological validity for the potential of the Azima Battery in everyday clinical practice.

The patterns of performance described and quantified were supported by prior literature, although no definitive pattern could be illustrated as distinctive for a final diagnosis of schizophrenia. However, maintaining an exclusive focus on refining this type of approach may or may not have yielded more definitive results. As described in Chapter Five, research in the discipline of psychology has been extensive yet no definitive, statistically significant sets of performance patterns stand on their own as a series of observable or quantifiable signs to detect a psychiatric diagnosis. As argued in section 6.6.3 of this thesis, it is necessary to shift from an exclusive quantitative research design to qualitative and mixed approaches to further elucidate the clinical reasoning underlying the ability of discriminant evaluators.

Another limitation is that there was no follow-up with the actual nine research participants. Follow-up data was only obtained from their medical records, and as such only provided information form the psychiatric perspective of what was deemed important in their trajectories. In proposing the Azima Battery as an engaging and recovery-oriented evaluation it would have been interesting to subsequently explore the perceptions of the participants of the evaluation session (Gunnarsson et al., 2010). Longitudinal interviewing with the participants would also have provided further depth of understanding as well as authentication of their constellation of meanings that were interpreted in the initial Azima Battery session.

Finally, individuals who were experiencing pre or early psychosis while homeless were not sampled in either the qualitative (n=9) or quantitative (N=62) parts of this study. This is a subgroup that has been under-represented and under-serviced by early psychosis services (Herman, Susser, Jandorf, Lavelle, & Bromet, 1998; Roy, Rousseau, Fortier, & Mottard, 2013). This is important to note in relation to the validity of, and

clinical reasoning for, the Azima Battery as the expression, structure, and meaning of the experiences of individuals who are homeless may be markedly different from the participants in this study (Desjarlais, 1994).

9.8. Future research

This is a manuscript-based thesis and, therefore, indications for future research were outlined within each manuscript. The reader is in particular referred to Figure 6.1 and section 6.6.3 for an overview of a potential research program for occupational therapy projective assessments. To restate here, the validity, utility, and clinical reasoning of specific projective assessments with particular client groups for both diagnostic and therapeutic purposes remains an open field of inquiry. Given the new DSM5 criteria and potential role of occupational therapists in contributing to mental health case formulation (Ordre des Ergothérapeutes du Quebec, 2015), the reserved act of psychiatric diagnosis in Quebec is understood in light of necessary interdisciplinary contributions to a final diagnosis (Office of Professional Orders in Quebec, 2013), in particular in youth mental health (Ministère de la Santé et des Services Sociaux, 2005). Thus, of political and strategic relevance for future research is the justification of the role of occupational therapists in mental health diagnostic practices.

In early psychosis and phenomenological psychopathology, the centrality of culture in both interpretation and in providing cultural safety has been highlighted. Therefore, future research refining the findings reported herein with different subgroups of individuals experiencing early psychosis and accessing specialized services would be important for both the quantitative and qualitative approaches used herein e.g. those who are homeless, non-immigrants, immigrants from different backgrounds.

Of interest would also be educational research for the implications made about occupational therapy clinical reasoning. The centrality of intuitive (Braude, 2013; Schmidt & McGowan, 1959) and narrative (Mattingly, 1998b) clinical reasoning, potential utility of metaphor theory (Kirmayer, 2004), and the importance of reflexive clarity about interpretive traditions (Kinsella, 2006a) have all been argued throughout this thesis. The call for reflexivity as the active interrogation of our ways of knowing (Phelan, 2011) and relating (McCorquodale & Kinsella, 2015) has recently become salient in a more globalized and culturally informed approach to occupational therapy (Gerlach, 2012; Kinsella, 2012a). Reflexivity, and self-awareness through reflective dialogue, is core to narrative reasoning (Mattingly, 1991a). At several places throughout this thesis it has been suggested to maintain projective assessments within academic programs, as well as providing outlines on how to teach about projective assessments. This implies two overlapping fields of inquiry for future research: articulating phenomenologically informed clinical reasoning and skills for reflective practice, and then translating this knowledge into successful educational strategies. The epistemological tensions and interpretive complexity of expressive assessments are a fertile space within occupational therapy curricula to operationalize and study these skills for clinical practice.

9.9 Concluding statement: Strengths and contributions

This doctoral project was a predominantly qualitative-mixed study. The clinical validity and utility of the Azima Battery in case formulation with youth recently admitted with a first episode of psychosis was demonstrated through a critical tracing of history, evidence, expertise and a tailored multi-method study design. The interpretations were driven by this researcher's horizons of meaning from over a decade of clinical experience with this patient group, ongoing dialogue with the supervisory committee and other key figures, as well as my pre-understandings from personal experiences and literature. I have attempted to be transparent about these throughout in order for the readers to critique, and come to their own conclusions. Philosophical hermeneutics posits that whatever has been disclosed, or emerges, is bound to conceal other possible interpretations or pathways to understanding. Hence, Davey's book title 'Unquiet Understanding' cautions us to both find the universal in the particular as well as to remain ready to change our position with new knowledge (Davey, 2006). At the start of this thesis, I compared the experience of conducting a mixed methods project to one of playing ragtime piano. Popular ragtime musician Scott Joplin is rumored to have recommended: 'play slowly until you catch the swing'. Eight years later, the hermeneutic thrust continues with you, the reader, interacting with this text, generating your own understanding and interpretations. The measure of the worth of the findings will depend on your own epistemologies and ethical orientations. For this author, the elements gained are:

(1) The design of a hermeneutic approach to mixed methods for the study of an evaluation tool provides an original epistemological and philosophical coherency for client-centred practice, by using an experience-near methodology to examine and refine an evaluation tool.
(2) Contribution to clinical philosophies and approaches that focus on the lived experience of the individual in conceptualizing and evaluating health care. These include the emerging field of whole person care in medicine (Hutchinson, 2011), the policy-mandated recovery orientation to mental health services (Mental Health Commission of Canada, 2015), the client-centred values of occupational therapy (Corring & Cook, 1999) and the call for cultural safety in both early psychosis intervention (Ehmann et al., 2010) and in occupational therapy (Gerlach, 2012).
(3) Ongoing articulation and illustration of occupational therapy narrative-phenomenological reasoning within the context and use of an expressive assessment in youth mental health, with ramifications for occupational therapy and occupational science theorizing about how to understand, listen to, and see what is meaningful for a client.
(4) Illumination of the ongoing diagnostic and predictive validity of the first standard assessment in occupational therapy in early psychosis intervention, from the vantage point of contemporary methodology, within a recovery-oriented landscape.
(5) Highlighting the Azima Battery's specific clinical utility in engaging and understanding the experiences of help-seeking immigrant youth experiencing psychosis.

If occupation is defined as 'meaningful doing', then occupational therapy needs evaluations that can both provide diagnostic information about the 'doing' or performance within the particularities of unstructured or expressive tasks, as well as shared understanding about the constellations of meaning, significant experiences, and modes-of-being that call a person into a shared world of doing.

REFERENCES

Addington, J., Chaves, A., & Addington, D. (2006). Diagnostic stability over one year in first-episode psychosis. *Schizophrenia Research, 86*(1-3), 71-75. doi: 10.1016/j.schres.2006.04.018

Addington, J., Francey, S. M., & Morrison, A. P. (2006). *Working with people at high risk of developing psychosis: A treatment handbook*. West Sussex, England: John Wiley & Sons.

Adeponle, A., Thombs, B., Groleau, D., Jarvis, G. E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services, 63*(2), 147-153. doi: 10.1176/appi.ps.201100280

Aiken, F. (2011). The meaning gap in occupational therapy: Finding meaning in our own occupation. *Canadian Journal of Occupational Therapy, 78*(5), 294-302. doi: 10.2182/cjot.2011.78.5.4

Alegria, M., Katz, A., Ishakawa, R. Z., Diaz-Linhart, Y., Valentine, A., & Lapatin, S. (2012). The role of sociocultural information in mental health intake sessions. *Israel Journal of Psychiatry & Related Sciences, 49*(3), 194-201.

Alleyne, A. (1980). Finger painting. A projective technique. *Canadian Journal of Occupational Therapy, 47*, 23-26.

Alvesson, M., & Sköldberg, K. (2009). *Reflexive methodology. New vistas for qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications Inc.

American Psychiatric Association. (1984). *Diagnostic and statistical manual of mental disorders. Revised.* (4th ed.). Washington, D.C.: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.) Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Amin, S., Singh, S. P., Brewin, J., Jones, P. B., Medley, I., & Harrison, G. (1999). Diagnostic stability of first-episode psychosis. Comparison of ICD-10 and DSM-III-R systems. *The British Journal of Psychiatry, 175*(6), 537-543. doi: 10.1192/bjp.175.6.537

Amos, S. P. (1982). The diagnostic, prognostic, and therapeutic implications of schizophrenic art. *The Arts in Psychotherapy, 9*(2), 131-1443.

Anastasi, A. (1982). *Psychological testing* (5th ed.). New York, NY: Macmillan Publishing Company.

Androes, L. R., Dreyfus, E. A., & Bloesch, M. (1965). Diagnostic test battery for occupational therapy. *American Journal of Occupational Therapy, 19*, 53-59.

Arieti, S. (1958/1974). *Interpretation of schizophrenia* (2nd ed.). New York: Basic Books.

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19-32.

Aronow, E., Reznikoff, M., & Moreland, K. L. (1995). The Rorschach: Projective technique or psychometric test? *Journal of Personality Assessment, 64*(2), 213-228.

Asher, L. A. (1989). *Occupational therapy assessment tools: An annotated index*. Bethesda, MD: AOTA, Inc.

Asher, L. A. (1996). *Occupational therapy assessment tools: An annotated index* (2nd ed.). Bethesda, MD: AOTA, Inc.

Atwood, G. E., Orange, D. M., & Stolorow, R. D. (2002). Shattered worlds/psychotic states: A post-Cartesian view of the experience of personal annihilation. *Psychoanalytic Psychology, 19*(2), 281-306. doi: 10.1037//0736-9735.19.2.281

Azima, H. (1961). Dynamic occupational therapy. *Diseases of the Nervous System, 22S*, 138-142.

Azima, H., & Azima, F. J. (1959). Outline of a dynamic theory of occupational therapy. *American Journal of Occupational Therapy, XIII*(5), 215-221.

Azima, H., & Wittkower, E. D. (1957). A partial field survey of psychiatric occupational therapy. *American Journal of Occupational Therapy, XI*(1), 1-7.

Barrett, R. (1996). *The Psychiatric Team and the Social Definition of Schizophrenia: An Anthropological Study of Person and Illness*. New York: Cambridge University Press.

Bazeley, P. (2009). Editorial: Integrating Data Analyses in Mixed Methods Research. *Journal of Mixed Methods Research, 3*(3), 203-207. doi: 10.1177/1558689809334443

Bazeley, P., & Kemp, L. (2011). Mosaics, Triangles, and DNA: Metaphors for Integrated Analysis in Mixed Methods Research. *Journal of Mixed Methods Research, 6*(1), 55-72. doi: 10.1177/1558689811419514

Behar, R. (1996). *The vulnerable observer. Anthropology that breaks your heart*. Boston, MA: Beacon Press.

Bell, M. D., & Stein, R. E. (1991). Ego function change through rehabilitation: A pilot study. *Psychosocial Rehabilitation Journal, 14*, 97-100.

Bendroth, S., & Southam, M. (1973). Objective evaluation of projective material. *American Journal of Occupational Therapy, 27*(2), 78-80.

Benner, P. (1994). The tradition and skill of interpetive phenomenology in studying health, illness, and caring practices. In P. Benner (Ed.), *Interpetive phenomenology. Embodiment, caring, and ethics in health and illness* (pp. 99-127). Thousand Oaks, CA: Sage Publications Inc.

Beran, M. (1955). *Projective techniques and their application to occupational therapy.* Paper presented at the American Occupational Therapy Association: A reassessment of professional education and practice in occupational therapy as related to rehabilitation, New York, N.Y.

Bertolote, J., & McGorry, P. D. (2005). Early intervention and recovery for young people with early psychosis: consensus statement. *British Journal of Psychiatry [Supplement], 48*, s116-119. doi: 10.1192/bjp.187.48.s116

Billig, O. (1969). *Spatial structure in schizophrenic art.* Paper presented at the 5th International Colloquium of Psychopathology of Expression. Psychiatry and art: Art interpretation and art therapy. , Los Angeles, CA.

Binswanger, L. (1987). *Mélancolie et Manie* (J.-M. Azorin & Y. Toyotan, Trans.). Paris: PUF.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., . . . Yeomans, D. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry, 201*(6), 430-434. doi: 10.1192/bjp.bp.112.109447

Bradfield, B. C., & Knight, Z. G. (2008). Intersubjectivity and the schizophrenic experience: A hermeneutic phenomenological exploration. *South African Journal of Psychology, 38*(1), 33-53.

Braude, H. D. (2013). Human all too human reasoning: comparing clinical and phenomenological intuition. *The Journal of Medicine and Philosophy, 38*(2), 173-189. doi: 10.1093/jmp/jhs057

Bruce, M. A. G., & Borg, B. (2002). *Psychosocial frames of reference. Core for occupation-based practice* (3rd ed.). Thorofare, NJ: Slack Inc.

Bruner, J. (1986). *Actual minds, possible worlds.* Cambridge, MA: Harvard University Press.

Bruner, J. (1990). *Acts of meaning.* Cambridge, MA: Harvard University Press.

Bruner, J. (2002). The narrative creation of self. In J. Bruner (Ed.), *Making stories: Law, literature, life* (pp. 63-87). New York, NY: Farrar, Straus and Giroux.

Buck, J. N. (1970). *House-Tree-Person technique: Manual (Revised).* Oxford, UK: Western Psychological Services.

Buck, R. E., & Provancher, M. A. (1972). Magazine picture collages as an evaluative technique. *American Journal of Occupational Therapy, 26*, 36-39.

Burton, A., & Sjoberg, B. (1964). The diagnostic validity of human figure drawings in schizophrenia. *Journal of Psychology, 57*, 3-18.

Butler-Kisber, L. (2008). Collage as inquiry. In G. Knowles & A. Cole (Eds.), *Handbook of the arts in qualitative research: Perspectives, methodologies, examples and issues* (pp. 265-276). Thousand Oaks, CA: Sage.

Canadian Institute for Health Information. (2011). Canadian Institute for Health Information Health Indicators 2011. Retrieved January 20, 2015, from http://www.cihi.ca

Centre for Community Child Health. (2011). Evidence-based practice and practice-based evidence: What does it all mean? [policy brief]. Retrieved July 7th, 2012, from http://ww2.rch.org.au/emplibrary/ecconnections/Policy_Brief_21_-_Evidence_based_practice_final_web.pdf

Centre for Evidence Based Medicine. (2009). Oxford Centre for Evidence Based Medicine-Levels of Evidence. Retrieved June 15, 2012, from http://www.cebm.net/index.aspx?o=1025

Chadwick, P. K. (2007). Peer-professional first-person account: schizophrenia from the inside--phenomenology and the integration of causes and meanings. *Schizophrenia Bulletin, 33*(1), 166-173. doi: 10.1093/schbul/sbl034

Chang, W. C., Chan, S. S. M., & Chung, D. W. S. (2009). Diagnostic stability of functional psychosis: A systematic review. *Hong Kong Journal of Psychiatry, 19*, 30-41.

Chang, W. C., Pang, S. L., Chung, D. W. S., & Chan, S. S. M. (2009). Five-year stability of ICD-10 diagnoses among Chinese patients presented with first-episode psychosis in Hong Kong. *Schizophrenia Research, 115*(2-3), 351-357. doi: 10.1016/j.schres.2009.09.037

Chapman, J. P. (1966). The early symptoms of schizophrenia. *British Journal of Psychiatry, 112*, 225-251.

Chapman, L. J., & Chapman, J. P. (1987). The search for symptoms predictive of schizophrenia. *Schizophrenia Bulletin, 13*, 497-503.

Chen-Sea, M.-J. (2000). Validating the Draw-A-Man test as a personal neglect test. *American Journal of Occupational Therapy, 54*(4), 392-397.

Chirila, C., & Feldman, A. (2012). How can we improve the existing assessments used in art therapy. A meta-analysis on art therapy assessments. *Procedia - Social and Behavioral Sciences, 33*, 358-362. doi: 10.1016/j.sbspro.2012.01.143

Choudhury, S. (2009). Culturing the adolescent brain: What can neuroscience learn from anthropology? *Social, Cognitive and Affective Neuroscience, 5*(2-3), 159-167.

Choudhury, S., & Slaby, J. (2012). *Critical neuroscience. A handbook of the social and cultural contexts of neuroscience* (S. Choudhury & J. Slaby Eds.). Oxford, UK: Wiley-Blackwell.

Christ, T. W. (2007). A recursive approach to mixed methods research in a longitudinal study of postsecondary education disability support services. *Journal of Mixed Methods Research, 1*(3), 226-241. doi: 10.1177/1558689807301101

Colbert, S. M., Peters, E. R., & Garety, P. A. (2006). Need for closure and anxiety in delusions: a longitudinal investigation in early psychosis. *Behaviour Research and Therapy, 44*(10), 1385-1396. doi: 10.1016/j.brat.2005.06.007

Cole, M. B. (2005). *Group dynamics in occupational therapy. The theoretical basis and practice application of group intervention* (3rd ed.). Thorofare, NJ: Slack, Inc.

Cole, M. B. (2011). *Group dynamics in occupational therapy. The theoretical basis and practice application of group intervention* (4th ed.). Thorofare, NJ: Slack, Inc.

Cook, J. V. (2001). *Qualitative research in occupational therapy: Strategies and experiences*. Scarborough, ON, Canada: Delmar.

Corin, E., & Lauzon, G. (1994). From symptoms to phenomena: The articulation of experience in schizophrenia. *Journal of Phenomenological Psychology, 25*, 3-50.

Corin, E., Thara, R., & Padmavati, R. (2005). Shadows of culture in psychosis in south India: a methodological exploration and illustration. *International Review of Psychiatry, 17*(2), 75-81. doi: 10.1080/09540260500050016

Correll, C. U., Manu, P., Olshanskiy, V., Napolitano, B., Kane, J. M., & Malhotra, A. K. (2009). Cardiometabolic risk of second-generation antipsychotic medications during first-time use in children and adolescents. *Journal of the American Medical Association, 302*(16), 1765-1773. doi: 10.1001/jama.2009.1549.

Corring, D. J., & Cook, J. V. (1999). Client-centred care means that I am a valued human being. *Canadian Journal of Occupational Therapy, 66*(2), 71-82.

Cramer-Azima, F. J. (1956). Personality changes and figure drawings: A case treated with ACTH. *Journal of Projective Techniques, 20*(2), 143-149.

Cramer-Azima, F. J. (1982). The Azima Battery: An overview. In B. J. Hemphill (Ed.), *The evaluative process in psychiatric occupational therapy* (pp. 57-62). Thorofare, NJ: Slack, Inc.

Cramer-Azima, F. J. (2012). [Research interview - May 5th, 2012].

Creek, J., & Lougher, L. (2008). *Occupational Therapy in Mental Health*. Philadelphia, PA: Elsevier Limited.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches*. CA: Sage.: Thousand Oaks.

Dana, R. H. (1975). Ruminations on teaching projective assessments: An ideology, specific usages, teaching practices. *Journal of Personality Assessment, 39*, 563-572.

Das-Munshi, J., Bécares, L., Boydell, J. E., Dewey, M. E., Morgan, C., Stansfeld, S. A., & Prince, M. J. (2012). Ethnic density as a buffer for psychotic experiences: findings from a national survey (EMPIRIC). *British Journal of Psychiatry, 201*, 282-290. doi: 10.1192/bjp.bp.111.102376

Davey, N. (2006). *Unquiet understanding. Gadamer's philosophical hermeneutics*. Albany, NY: State University of New York Press.

Davidson, L. (2003a). Eliciting narratives. In L. Davidson (Ed.), *Living outside mental illness. Qualitative studies of recovery in schizophrenia* (pp. 61-92). New York, NY: New York University Press.

Davidson, L. (2003b). *Living outside mental illness. Qualitative studies of recovery in schizophrenia*. New York, NY: New York University Press.

Davidson, L., Staeheli, M., Stayner, D., & Sells, D. (2004). Language, suffering, and the question of immanence: Toward a respectful phenomenological psychopathology. *Journal of Phenomenological Psychology, 35*(2), 197-232.

Deegan, P. (2005). Recovery as a journey of the heart. In L. Davidson, C. Hardgin & L. Spaniol (Eds.), *Recovery from severe mental illnesses: Research evidence and implications* (pp. 57-68). Boston, MA: Center for Psychiatric Rehabilitation, Boston University.

Desjarlais, R. (1994). Struggling along: The possibilites for experience among the homeless mentally ill. *American Anthropologist, 96*(4), 886-901.

Desjarlais, R., & Jason Throop, C. (2011). Phenomenological Approaches in Anthropology. *Annual Review of Anthropology, 40*(1), 87-102. doi: 10.1146/annurev-anthro-092010-153345

Dewey, J. (1934/1980). *Art as experience*. New York, NY: Penguin Group.

Doubt, K. (1994). A Burkean hermeneutics for understanding the social character of schizophrenic language. *Symbolic Interaction, 17*(2), 129-146. doi: http://dx.doi.org/10.1525/si.1994.17.2.129

Dragt, S., Nieman, D. H., Veltman, D., Becker, H. E., van de Fliert, R., de Haan, L., & Linszen, D. H. (2011). Environmental factors and social adjustment as predictors of a first psychosis in subjects at ultra high risk. *Schizophrena Research, 125*(1), 69-76. doi: 10.1016/j.schres.2010.09.007

Dreyfus, H. L. (1991). *Being-in-the-world. A commentary on Heidegger's Being and Time, Division 1*. Cambridge, MA: The MIT Press.

Dreyfus, H. L. (2011). Medicine as combining natural and human science. *The Journal of Medicine and Philosophy, 36*(4), 335-341. doi: 10.1093/jmp/jhr027

Duncan, E. A. S., & Nicol, M. N. (2004). Subtle realism and occupational therapy: An alternative approach to knowledge generation and evaluation. *British Journal of Occupational Therapy, 67*(10), 453-456.

Edwards, D. (2004). *Art therapy*. Thousand Oaks, CA: Sage Publications.

Edwards, I., Jones, M., Carr, J., Braunack-Mayer, A., & Jensen, G. M. (2004). Clinical reasoning strategies in physical therapy. *Physical Therapy, 84*(4), 312-330.

Ehmann, T., Hanson, L., Yager, J., Dalzell, K., & Gilbert, M. (2010). *Standards and Guidelines for Early Psychosis Intervention (EPI) Programs.* British Columbia: British Columbia Ministry of Health Services.

Eisner, E. (2008). Art and knowledge. In J. G. Knowles & A. L. Cole (Eds.), *Handbook of the Arts in Qualitative Research*. Thousand Oaks, CA: Sage Publications Inc.

Eklund, M. (2000). Applying object relations theory to psychosocial occupational therapy: Empirical and theoretical considerations. *Occupational Therapy in Mental Health, 15*(1), 1-26.

Eklund, M. (2002). Explicit and implicit methods in occupational therapy. *Occupational Therapy in Mental Health, 18*(2), 3-15.

Eklund, M., & Nilsson, A. (1999). Changes in object relations in long-term mentally ill patients treated in a psychiatric day-care unit. *Psychotherapy Research, 9*(2), 167-183. doi: 10.1080/10503309912331332671

Engin, M. (2011). Research diary: A tool for scaffolding. *International Journal of Qualitative Methods, 10*(3), 293-306.

EPPIC. (1988-2014). Early Psychosis Prevention and Intervention Centre - Psychosis. Retrieved April 30, 2014, from http://eppic.org.au/psychosis

Exner, J. E. (1974). *The Rorschach: A Comprehensive System. Volume 1: Basic Foundations* (2nd ed.). New York, NY: Wiley.

Farnham, B. T., & Chase, P. H. (1982). The FEL Process: A visual life style. *Individual Psychology: Journal of Adlerian Theory, Research & Practice, 38*(2), 147-153.

Fidler, G. S. (1957). The role of occupational therapy in a multi-discipline approach to psychiatric illness. *American Journal of Occupational Therapy, XI*(1), 8-12.

Fidler, G. S. (1968). *Diagnostic Battery: Scoring and summary.* Paper presented at the American Occupational Therapy Association Final Report: On the Evaluation Process - 1968 Regional Institutes, sponsored by the American Occupational Therapy Association, New York, NY.

Fidler, G. S. (1982). The Activity Laboratory: A structure for observing and assssing perceptual, integrative, and behavioral strategies. In B. J. Hemphill (Ed.), *The evaluative process in psychiatric occupational therapy* (pp. 195-208). Thorofare, NJ: Slack Inc.

Fidler, G. S. (1995). Position paper: The psychosocial core of occupational therapy. *American Journal of Occupational Therapy, 49*(10), 1021-1022.

Fidler, G. S., & Fidler, J. W. (1954). *Introduction to psychiatric occupational therapy*. New York, NY: Macmillan Publishing Co.

Fidler, G. S., & Fidler, J. W. (1963). *Occupational therapy. A communication process in psychiatry*. New York, NY: Macmillan Publishing Co.

Fidler, G. S., & Fidler, J. W. (1978). Doing and becoming: Purposeful action and self-actualization. *American Journal of Occupational Therapy, 32*(5), 305-310.

Fidler, G. S., & Velde, B. (1999). *Activities: Reality and symbol*. Thorofare, NJ: Slack, Inc.

Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology, 39*, 1-32.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology and Practice, 3*(1), 6-25.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment, 9*(4), 374-385.

Fleming, M. H., & Mattingly, C. (2000). Action and narrative: Two dynamics of clinical reasoning. In J. Higgs & M. Jones (Eds.), *Clinical reasoning in the health professions* (2nd ed., pp. 54-61). Oxford, UK: Butterworth-Heinemann.

Foster, F. (1997). Fear of three-dimensionality: Clay and plasticine as experimental bodies. In K. Killick & J. Schaverien (Eds.), *Art, psychotherapy and psychosis* (pp. 52-71). East Sussex, UK: Routledge.

Fraguas, D., Castro, M. J., Medina, O., Parellada, M., Moreno, D., Graell, M., . . . Arango, C. (2007). Does diagnostic classification of early-onset psychosis change over follow-up? *Child Psychiatry and Human Development, 39*(2), 137-145. doi: 10.1007/s10578-007-0076-3

Frank, L. K. (1948). *Projective methods*. Chicago, IL: Charles C. Thomas Publisher.

Friedland, J. (2011). *Restoring the spirit: The beginnings of occupational therapy in Canada, 1890-1930*. Montreal, QC, Canada: McGill-Queen's University Press.

Friedman, I. (1952). Art therapy, an aid to reintegrative processes. *American Journal of Occupational Therapy, 6*, 64-65.

Friedman, I. (1953). Art in therapy: An outline of suggested procedures. *American Journal of Occupational Therapy, 7*, 169-170.

Frye, B. (1990). Art and multiple personality disorder: An expressive framework for occupational therapy. *American Journal of Occupational Therapy, 44*, 1013-1020.

Fuchs, T., & Jaegher, H. (2009). Enactive intersubjectivity: Participatory sense-making and mutual incorporation. *Phenomenology and the Cognitive Sciences, 8*(4), 465-486. doi: 10.1007/s11097-009-9136-4

Garb, H. N. (2003). Incremental validity and the assessment of psychopathology in adults. *Psychological Assessment, 15*(4), 508-520. doi: 10.1037/1040-3590.15.4.508

Gerlach, A. J. (2012). A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy, 79*(3), 151-158. doi: 10.2182/cjot.2012.79.3.4

Ginev, D. (1995). Between epistemology and hermeneutics. *Science & Education, 4*, 147-159.

Ginev, D. (1998). Rhetoric and double hermeneutics in the human sciences. *Human Studies, 21*, 259-271.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of Grounded Theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishing Company.

Goodman Evaskus, M. (1982). The Goodman Battery. In B. J. Hemphill (Ed.), *The evaluative process in psychiatric occupational therapy* (pp. 85-126). Tohorfare, NJ: Slack, Inc.

Green, C. (2001). Collaboration as symptom. Retrieved from Collaborative Arts. Conversations on Collaborative Arts Practise website: http://collabarts.org/?p=4

Groleau, D., Young, A., & Kirmayer, L. J. (2006). The McGill Illness Narrative Interview (MINI): An interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry, 43*(4), 671-691.

Gunnarsson, A. B., Jansson, J.-Å., & Eklund, M. (2006). The Tree Theme Method in psychosocial occupational therapy: A case study. *Scandinavian Journal of Occupational Therapy, 13*(4), 229-240. doi: 10.1080/11038120600772908

Gunnarsson, A. B., Peterson, K., ., Leufstadius, C., Jansson, J. A., & Eklund, M. (2010). Client perceptions of the Tree Theme Method: A structured intervention based on storytelling and creative activities. *Scandinavian Journal of Occupational Therapy, 17*(3), 200-208.

Hammell, K. W. (2007). Reflections on… a disability methodology for the client-centred practice of occupational therapy research. *Canadian Journal of Occupational Therapy, 74*(5), 365-369.

Hammell, K. W. (2013). Client-centred occupational therapy in Canada: Refocusing on core values / Recentrer l'ergotherapie au Canada sur les valeurs fondamentales de la pratique centree sur le client. *Canadian Journal of Occupational Therapy, 80*(3), 141-149. doi: 10.1177/0008417413497906

Hammer, E. F. (1958). *The clinical application of projective drawings*. Chicago, IL: Charles C. Thomas Publisher.

Hammer, E. F. (1958/1980). Recent variations of the projective drawing techniques. In E. F. Hammer (Ed.), *The clinical application of projective drawings* (6th ed., pp. 391-480). Springfield, IL: Charles C. Thomas Publisher.

Hammer, E. F. (1981). Projective drawings. In A. I. Rabin (Ed.), *Assessment with projective techniques: A concise introduction*. New York, NY: Springer.

Han Men, A. (2004). Has the focus on evidence based practice led occupational therapy astray from its arts and crafts foundations? Retrieved June 6th, 2012, from http://www.pugetsound.edu/files/resources/2804_HanMen2004.rtf

Hanson, W. E., Creswell, J. W., Plano Clark, V. L., Petska, K. S., & Creswell, J. D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology, 52*, 224-235.

Harding, S. (1987). *Feminism and methodology*. Bloomington, IN: Indiana University Press.

Harland, R. (2007). Why the phenomenology remains foundational. *Philosophy, Psychiatry & Psychology, 13*(3), 247-249.

Harland, R., Morgan, C., & Hutchinson, G. (2004). Phenomenology, science and the anthropology of the self: A new model for the aetiology of psychosis. *British Journal of Psychiatry, 185*, 361-362.

Harper, D. (2001-2014). Online Etymology Dictionary. Retrieved April 28, 2014, from http://www.etymonline.com/

Harris, C. (1997). Professional focus: Occupational therapists in mental health need to learn some crafty moves. *Therapy Weekly, February*.

Harris, D. B. (1963). *Goodenough-Harris Drawing Test Manual*. San Diego, CA: Harcourt, Brace & World.

Harrop, C., & Trower, P. (2003). *Why does schizophrenia develop in late adolescence? A cognitive-developmental approach to psychosis*. England: John Wiley & Sons, Ltd.

Harrower, M. R. (1958/1980). The Most Unpleasant Concept Test. A graphic projective technique for diagnostic and therapeutic use. In E. F. Hammer (Ed.), *The clinical application of projective drawings* (6th ed., pp. 365-390). Springfield, IL: Charles C. Thomas Publisher.

Hasselkus, B. R. (2011). *The meaning of everyday occupation* (2nd ed.). Thorofare, NJ: Slack Inc.

Health Canada. (2002). *A Report on Mental Illnesses in Canada*. Ottawa, Canada: Author Retrieved from http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf.

Heidgerd, E. (1958/1980). Research in drawing techniques. In E. F. Hammer (Ed.), *The clinical application of projective drawings* (6th ed., pp. 483-507). Springfield, IL: Charles C. Thomas Publisher.

Heine, D., & Steiner, M. (1986). Standardised paintings as a proposed adjunct instrument for longitudinal monitoring of mood states: A preliminary note. *Occupational Therapy in Mental Health, 6*, 31-37.

Helfrich, C., Kielhofner, G., & Mattingly, C. (1994). Volition as narrative: Understanding motivation in chronic illness. *American Journal of Occupational Therapy, 48*(4), 311-317.

Hemphill, B. J. (1982a). *The evaluative process in psychiatric occupational therapy*. Thorofare, NJ: Slack, Inc.

Hemphill, B. J. (1982b). *Training manual for the BH Battery*. Thorofare, NJ: Slack, Inc.

Hemphill-Pearson, B. J. (2008). *Assessments in occupational therapy mental health. An integrative approach* (2nd ed.). Thorofare, NJ: Slack, Inc.

Henry, L. P., Harris, M. G., Amminger, G. P., Yuen, H. P., Harrigan, S. M., Lambert, M., . . . McGorry, P. D. (2007). Early Psychosis Prevention and Intervention Centre long-term follow-up study of first-episode psychosis: methodology and baseline characteristics. *Early Intervention in Psychiatry, 1*(1), 49-60. doi: 10.1111/j.1751-7893.2007.00008.x

Herman, D. B., Susser, E. S., Jandorf, L., Lavelle, J., & Bromet, E. J. (1998). Homelessness among individuals with psychotic disorders hospitalized for the first time: Findings from the Suffolk County Mental Health Project. *American Journal of Psychiatry, 155*(1), 109-113.

Higgs, G. E. (2008). Psychology: Knowing the self through arts. In J. G. Knowles & A. L. Cole (Eds.), *Handbook of the Arts in Qualitative Research.* . Thousand Oaks, CA: Sage Publications Inc.

Holtzman, C. W., Larson, M. K., Addington, J., Cadenhead, K., Cannon, T. D., Cornblatt, B., . . . Seidman, L. J. (2010). Sex differences in symptom presentation in individuals at risk for psychosis. *Schizophrenia Research, 117*(2-3), 304-305. doi: 10.1016/j.schres.2010.02.508

Horan, W. P., Reise, S. P., Subotnik, K. L., Ventura, J., & Nuechterlein, K. H. (2008). The validity of Psychosis Proneness Scales as vulnerability indicators in recent-onset schizophrenia patients. *Schizophrenia Research, 100*(1-3), 224-236. doi: 10.1016/j.schres.2007.12.469

Hunt, H. T. (2007). "Dark nights of the soul": Phenomenology and neurocognition of spiritual suffering in mysticism and psychosis. *Review of General Psychology, 11*(3), 209-234. doi: 10.1037/1089-2680.11.3.209

Hutchinson, T. A. (Ed.). (2011). *Whole Person Care. A New Paradigm for the 21st Century*. New York, NY: Springer Science & Business Media, LLC.

Ikiugu, M. N. (2010). The new occupational therapy paradigm: Implications for integration of the psychosocial core of occupational therapy in all clinical specialties. *Occupational Therapy in Mental Health, 26*(4), 343-353. doi: 10.1080/0164212x.2010.518284

Ilonen, T., Taiminen, T., Karlsson, H., Lauerma, H., Leinonen, K.-M., Wallenius, E., . . . Salokangas, R. K. (1999). Diagnostic efficiency of the Rorschach schizophrenia and depression indices in identifying first-episode schizophrenia and severe depression. *Psychiatry Research, 87*, 183-192.

Ivarsson, A.-B., Söderback, I., & Ternestedt, B.-M. (2002). The meaning and form of occupational therapy as experienced by women with psychoses: a phenomenological study. *Scandinavian Journal of Caring Sciences, 16*(1), 103-110. doi: DOI: 10.1046/j.1471-6712.2002.00064.x

Iwama, M. (2006). *The Kawa Model; culturally relevant occupational therapy*. Edinburgh, Scotland: Churchill Livingstone-Elsevier Press.

Jackson, C., & Birchwood, M. (1996). Early intervention in psychosis: Opportunities for secondary prevention. *British Journal of Clinical Psychology, 35*, 487-502.

Jackson, H. J., McGorry, P. D., & Dudgeon, P. (1995). Prodromal symptoms of schizophrenia in first-episode psychosis: Prevalence and specificity. *Comprehensive Psychiatry, 36*(4), 241-250.

Jackson, M. (1983). Thinking through the body: an essay on understanding metaphor. *Social Analysis, 14*, 127-149.

Jackson, M. (1996). Introduction: Phenomenology, radical empiricism, and anthropological critique. In M. Jackson (Ed.), *Things as They Are. New Directions in Phenomenological Anthropology* (pp. 1-50). Bloomington and Indianapolis: Indiana University Press.

Jackson, M. (1998). *Minima ethnographica. Intersubjectivity and the anthropological project*. Chicago, IL: The University of Chicago Press.

Jackson, M. (2005). *Existential anthropology. Events, exigencies, effects*. New York and Oxford: Berghahn Books.

Jackson, M. (2009). *The palm at the end of the mind ~ Relatedness, religiosity, and the real*. Durham and London: Duke University Press.

Jackson, M. (2010). From anxiety to method in anthropological fieldwork: An appraisal of George Devereux's enduring ideas. In J. Davies & D. Spencer (Eds.), *Emotions in the Field* (pp. 35-54). Stanford, CA: Stanford University Press.

Jaspers, K. (1959/63). *General Psychopathology. Volume One* (J. Hoenig & M. W. Hamilton, Trans.). Baltimore, MD: Johns Hopkins University Press.

Johnson, M. (1987). *The body in the mind. The bodily basis of meaning, imagination, and reason.* Chicago, IL: University of Chicago Press.

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Towards a definition of mixed methods research. *Journal of Mixed Methods Research, 1*, 112-133.

Kalla, O., Wahlström, J., Aaltonen, J., Holma, J., Tuimala, P., & Mattlar, C.-E. (2004). Rorschach characteristics and comparison of first-episode psychotic patients in Finland and Spain. *Rorschachiana, 26*, 63-84.

Katz, A. M., & Shotter, J. (1996). Hearing the patient's 'voice': Toward a social poetics in diagnostic interviews. *Social Science in Medicine, 43*(6), 919-931.

Kavanagh, G. (1994). *A review of the literature relating to the use of art in occupational therapy groups within the field of mental health.* (Unpublished dissertation). Queen Margaret College, Edinburgh, Scotland.

Kielhofner, G. (2008). *Model of Human Occupation. Theory and application* (4th ed.). Baltimore, MD: Lippincottt, Williams & Wilkins.

Kim, J. S., Baek, J. H., Choi, J. S., Lee, D., Kwon, J. S., & Hong, K. S. (2011). Diagnostic stability of first-episode psychosis and predictors of diagnostic shift from non-affective psychosis to bipolar disorder: A retrospective evaluation after recurrence. *Psychiatry Research, 188*(1), 29-33. doi: 10.1016/j.psychres.2010.09.017

Kinsella, E. A. (2006a). Hermeneutics and critical hermeneutics: Exploring possibilites within the art of interpretation. *Forum: Qualitative Social Research, 7*(3), Article 19. http://www.qualitative-research.net/fqs-texte/3-06/06-3-19-e.htm

Kinsella, E. A. (2006b). Poetic resistance: Juxtaposing personal and professional discursive constructions in a practice context. *Journal of the Canadian Association for Curriculum Studies, 4*(1), 35-49.

Kinsella, E. A. (2012a). Knowledge paradigms in occupational science: Pluralistic perspectives. In G. Whiteford & C. Hocking (Eds.), *Occupational Science: Society, Inclusion, Participation* (pp. 67-85). Oxford, UK: Blackwell Publishing Ltd.

Kinsella, E. A. (2012b). Practitioner reflection and judgement as phronesis: A continuum of reflection and considerations for phronetic judgement. In E. A. Kinsella & A. Pitman (Eds.), *Phronesis as professional knolwedge: Practical wisdom in the professions* (pp. 35-52). Rotterdam, Netherlands: Sense Publishers.

Kirby, M. J. L., & Keon, W. J. (2006). *Out of the shadows at last. Transforming mental health, mental illness and addiction services in Canada.* Ottawa, ON, Canada: Canadian Senate: Committee on Social Affairs Science and Technology. Retrieved from http://www.parl.gc.ca.

Kirmayer, L. J. (1992). The body's insistence on meaning: Metaphor as presentation and representation in illness experience. *Medical Anthropology Quarterly, 6*(4), 323-346.

Kirmayer, L. J. (2004). The cultural diversity of healing: meaning, metaphor and mechanism. *British Medical Bulletin, 69*, 33-48. doi: 10.1093/bmb/ldh006

Kirmayer, L. J. (2007). Celan's poetics of alterity. *Monash Bioethics Review, 26*(4), 21-35.

Kirmayer, L. J. (2008a). Culture and the metaphoric mediation of pain. *Transcultural Psychiatry, 45*(2), 318-338. doi: 10.1177/1363461508089769

Kirmayer, L. J. (2008b). Empathy and alterity in cultural psychiatry. *Ethos, 36*(4), 457-474. doi: 10.1111/j.1548-1352.2008.00027.x

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine, 75*(2), 249-256. doi: 10.1016/j.socscimed.2012.03.018

Klosterkötter, J., Hellmich, M., Steinmeyer, E. M., & Schultze-Lutter, F. (2001). Diagnosing schizophrenia in the initial prodromal phase. *Archives of General Psychiatry, 58*, 158-164.

Kossak, M. S. (2009). Therapeutic attunement: A transpersonal view of expressive arts therapy. *The Arts in Psychotherapy, 36*(1), 13-18. doi: 10.1016/j.aip.2008.09.003

Kraepelin, E. (1962). *100 Years of Psychiatry*. New York: Philosophical Library.

Kramer, E. S., & Iager, A.-C. (1984). The use of art in assessment of psychotic disorders: Changing perspectives. *The Arts in Psychotherapy, 11*, 197-201.

Krupa, T. (2008). Part of the solution…or part of the problem? Addressing the stigma of mental illness in our midst. *Canadian Journal of Occupational Therapy, 75*(4), 198-206.

Kvale, S., & Brinkmann, S. (2009). *InterViews. Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Laliberte-Rudman, D., & Moll, S. (2001). In-depth interviewing. In J. V. Cook (Ed.), *Qualitative Research In Occupational Therapy*. Canada: Delmar.

Lanham, R. (2002). Inscape revisited. *International Journal of Art Therapy, 77*(2), 48-59.

Lanier, W. L., & Rajkumar, S. V. (2013). Empiricism and rationalism in medicine: Can 2 competing philosophies coexist to improve the quality of medical care? *Mayo Clinic Proceedings, 88*(10), 1042-1045. doi: 10.1016/j.mayocp.2013.08.005

Larsen, J. A. (2004). Finding meaning in first episode psychosis: Experience, agency, and the cultural repertoire. *Medical Anthropology Quarterly, 18*(4), 447-471.

Larsen, J. A. (2007a). Symbolic healing of early psychosis: psychoeducation and sociocultural processes of recovery. *Culture, Medicine and Psychiatry, 31*(3), 283-306. doi: 10.1007/s11013-007-9055-1

Larsen, J. A. (2007b). Understanding a complex intervention: Person-centred ethnography in early psychosis. *Journal of Mental Health, 16*(3), 333-345. doi: 10.1080/09638230701299186

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3). http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf

Lawlor, M. C. (2003). Gazing anew: The shift from a clinical gaze to an ethnographic lens. *American Journal of Occupational Therapy, 57*(1), 29-39.

Lawn, E. C., & O'Kane, C. P. (1973). Psychosocial symbols as communication media. *American Journal of Occupational Therapy, 27*, 30-33.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). A conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry, 199*, 445-452.

Leavy, P. (2009). Social research and the creative arts. An introduction. In P. Leavy (Ed.), *Method Meets Arts. Arts-Based Research Practice* (pp. 1-24). New York: The Guilford Press.

Lerner, C. J. (1979). The Magazine Picture Collage: Its clinical use and validity as an assessment device. *American Journal of Occupational Therapy, 33*(8), 500-504.

Lerner, C. J. (1982). The Magazine Picture Collage. In B. J. Hemphill (Ed.), *The evaluative process in psychiatric occupational therapy* (pp. 139-154). Thorofare, NJ: Slack, Inc.

Lerner, C. J., & Ross, G. (1977). The Magazine Picture Collage: Development of an objective scoring system. *American Journal of Occupational Therapy, 31*(3), 156-161.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: Advancing the methodology. *Implementation Science, 5*(69), 1-9.

Levesque, R. (2007). *SPSS Programming and Data Management: A Guide for SPSS and SAS Users* (4th Ed. ed.). Chicago, IL: SPSS Inc.

Levine, I., O'Connor, H. O., & Stacey, B. (1977). Sensory integration with chronic schizophrenics: A pilot study. *Canadian Journal of Occupational Therapy, 44*(1), 17-21.

Lezak, M. D. (1983). *Neuropsychological assessment* (2nd ed.). New York, NY Oxford University Press.

Li, C.-Y., Chen, T.-J., Helfrich, C., & Pan, A.-W. (2011). The development of a scoring system for the Kinetic House-Tree-Person Drawing Test. *Hong Kong Journal of Occupational Therapy, 21*(2), 72-79. doi: 10.1016/j.hkjot.2011.10.004

Liberman, F., Samea, M., & Rosa, S. D. (2011). Laboratories: Expressive activities in the development of the occupational therapist. *Cadernos de Terapia Ocupacional da UFSCar (Journal of Occupational Therapy-UFSCar), 19*, 81-92.

Lilienfeld, S. O., Wood, J. M., & Garb, H. N. (2000). The scientific status of projective techniques. *Psychological Science in the Public Interest, 1*, 27-66.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lindzey, G. (1961). *Projective techniques and cross-cultural research*. New York, NY: Appleton-Century-Crofts.

Llorens, L. A. (1963). Finger-painting with an obsessive-compulsive organically-damaged child. *American Journal of Occupational Therapy, XVII*, 120-121.

Llorens, L. A. (1967). Projective technique in occupational therapy. *American Journal of Occupational Therapy, 21*, 226-229.

Lloyd, C., & Papas, V. (1999). Arts as therapy within occupational therapy in mental health settings: A review of the literature. *British Journal of Occupational Therapy, 62*(1), 31-35.

Loevinger, J., & Wessler, R. (1970). *Measuring ego development, volume 1: Construction and use of a Sentence Completion Test*. San Francisco, CA: Jossey-Bass Inc Pub.

Louet, E., Consoli, A., Lucanto, R., Duplant, N., Bailly-Salin, M. J., Lemoigne, A., . . . Cohen, D. (2010). Psychodynamic-oriented psychological assessment predicts evolution to schizophrenia at 8-year follow-up in adolescents hospitalized for a manic/mixed episode: Interest of an overall subjective rating. *Journal of Physiology, Paris, 104*(5), 257-262. doi: 10.1016/j.jphysparis.2010.08.004

Luhrmann, T. M. (2000). *Of two minds. An anthropologist looks at American psychiatry*. New York, NY: Vintage Books.

Lysaker, J., & Lysaker, P. (2005). Being interrupted: The self and schizophrenia. *The Journal of Speculative Philosophy, 19*(1), 1-21. doi: 10.1353/jsp.2005.0001

Lysaker, P. H., Glynn, S. M., Wilkniss, S. M., & Silverstein, S. M. (2010). Psychotherapy and recovery from schizophrenia: A review of potential applications and need for future study. *Psychological Services, 7*(2), 75-91. doi: 10.1037/a0019115

Lysaker, P. H., & Lysaker, J. T. (2002). Narrative structure in psychosis: Schizophrenia and disruptions in the dialogical self. *Theory & Psychology, 12*(2), 207-220. doi: 10.1177/0959354302012002630

MacFarlane, J. W., & Tuddenham, R. D. (1951). Problems in the validation of projective techniques. In H. H. Andersen & G. L. Andersen (Eds.), *An introduction to projective techniques and other devices for understanding the dynamics of human behavior* (pp. 26-54). Englewood Cliffs, NJ: Prentice-Hall Inc.

Machover, K. (1949). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C. Thomas Publisher.

Malcolm, M. (1975). Art as projective technique. *British Journal of Occupational Therapy, 38*(July), 147-148.

Marcus, E. R. (1992). *Psychosis and near psychosis. Ego function, symbol structure, treatment*. New York, NY: Springer-Verlag.

Mattingly, C. (1991a). The narrative nature of clinical reasoning. *American Journal of Occupational Therapy, 45*, 998-1005. doi: 10.5014/ajot.45.11.998.

Mattingly, C. (1991b). What is clinical reasoning? *American Journal of Occupational Therapy, 45*, 979-986. doi: 10.5014/ajot.45.11.979

Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science & Medicine, 38*, 811-822. doi: http://dx.doi.org/10.1016/0277-9536(94)90153-8.

Mattingly, C. (1998a). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge, UK: Cambridge University Press.

Mattingly, C. (1998b). In search of the good: Narrative reasoning in clinical practice. *Medical Anthropology Quarterly, 12*(3), 273-297.

Mattingly, C. (2008). Reading minds and telling tales in a cultural borderland. *Ethos, 36*(1), 136-154.

Mattingly, C. (2010a). Narrative matters. In C. Mattingly (Ed.), *The paradox of hope. Journeys through a clinical borderland.* (pp. 37-76). Los Angeles, CA: University of California Press.

Mattingly, C. (2010b). *The paradox of hope. Journeys through a clinical borderland*. Los Angeles, CA: University of California Press.

Mattingly, C. (2013). Moral selves and moral scenes: Narrative experiments in everyday life. *Ethnos, 78*(3), 301-327. doi: 10.1080/00141844.2012.691523

Mattingly, C. (2014). *Moral laboratories. Family peril and the struggle for a good life*. Oakland, CA: University of California Press.

Mattingly, C., & Fleming, M. H. (1994). *Clinical reasoning: Forms of inquiry in a therapeutic practice*. Philadelphia, PA: F. A. Davis Press.

Mattingly, C., & Lawlor, M. (2001). The fragility of healing. *Ethos, 29*(1), 30-57.

Mattingly, C., & Lawlor, M. C. (2000). Learning from stories: Narrative interviewing in cross-cultural research. *Scandinavian Journal of Occupational Therapy, 7*, 4-14.

Maxmen, A. (2012). Psychosis risk syndrome excluded from DSM-5. *Nature, May*. Retrieved from http://www.nature.com/news/psychosis-risk-syndrome-excluded-from-dsm-5-1.10610 website: doi:10.1038/nature.2012.10610

Mayoh, J., & Onwuegbuzie, A. J. (2013). Toward a conceptualization of mixed methods phenomenological research. *Journal of Mixed Methods Research, Advanced online publication*, 1-17. http://mmr.sagepub.com/content/early/2013/09/25/1558689813505358.abstract doi:10.1177/1558689813505358

McCorquodale, L., & Kinsella, E. A. (2015). Critical reflexivity in client-centred therapeutic relationships. *Scandinavian Journal of Occupational Therapy*, 1-7. doi: 10.3109/11038128.2015.1018319

McGorry, P. D. (1992). The concept of recovery and secondary prevention in psychotic disorders. *Australian and New Zealand Journal of Psychiatry, 26*, 3-17.

McGorry, P. D., McFarlane, C., Patton, G., Bell, R. Q., Dudgeon, P., Hibbert, M., . . . Bowes, G. (1995). The prevalence of prodromal features of schizophrenia in adolescence: A preliminary survey. *Acta Psychiatrica Scandinavica, 92*(4), 241-249.

McGorry, P. D., Yung, A. R., & Phillips, L. J. (2003). The "Close-in" or ultra high-risk model: A safe and effective strategy for research and clinical intervention in prepsychotic mental disorder. *Schizophrenia Bulletin, 29*, 771-790.

Meehl, P. E. (1986). Diagnostic taxa as open concepts: Metatheoretical and statistical questions about reliability and construct validity in the grand strategy of nosological revision. In T. Millon & G. Klerman (Eds.), *Contemporary directions in psychopathology: Toward the DSM-IV* (pp. 215-231). New York, NY: Guilford.

Menks, F. (1973). Drawings by frustrated and nonfrustrated four-year-olds. *American Journal of Occupational Therapy, 27*(6), 336-338.

Mental Health Commission of Canada. (2009). *Toward recovery and well-being. A framework for a mental health strategy for Canada.* Calgary, AB, Canada: Author. Retrieved from http://www.mentalhealthcommission.ca.

Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada.* Calgary, AB, Canada: Author Retrieved from http://www.mentalhealthcommission.ca.

Mental Health Commission of Canada. (2015). *Recovery guidelines.* Ottawa, ON: Author.

Mental Health Evaluation & Community Consultation Unit. (2000). *Early Psychosis. A Guide for Physicians.* Vancouver, B.C.: Government of British Columbia Retrieved from http://www.health.gov.bc.ca/library/publications/year/2000/EarlyPsychosis_PhysicianGuide.pdf.

Meredith, P. (2009). Introducing attachment theory to occupational therapy. *Australian Occupational Therapy Journal, 56*(4), 285-292. doi: 10.1111/j.1440-1630.2009.00789.x

Meredith, P., Merson, K., & Strong, J. (2007). Differences in adult attachment style, career choice and career satisfaction for occupational therapy and commerce students. *British Journal of Occupational Therapy, 70*(6), 235-242.

Merleau-Ponty, M. (1945). *Phénoménologie de la Perception*. Paris, France: Éditions Gallimard.

Merriam-Webster. (Ed.) (1997). New York: Gramercy Books.

Meyer, A. (1922). The philosophy of occupational therapy. *Archives of Occupational Therapy, 1*(1), 1-10.

Miller, L. D. (1970). Humor as a projective technique in occupational therapy. *American Journal of Occupational Therapy, 24*, 201-204.

Miller, W. L., & Crabtree, B. F. (2005). Clinical research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 605-639). London, England: Sage Publications.

Milligan, E., & Woodley, E. (2009). Creative expressive encounters in health ethics education: teaching ethics as relational engagement. *Teach Learn Med, 21*(2), 131-139. doi: 10.1080/10401330902791248

Ministère de la Santé et des Services Sociaux. (1989). *Politique de Santé Mentale.* Quebec: Author.

Ministère de la Santé et des Services Sociaux. (2005). *Plan d'Action en Santé Mentale. La Force des Liens.* Quebec: Author Retrieved from http://www.msss.gouv.qc.ca.

Minkoff, Y., & Riley, J. (2011). Perspectives of time-use: Exploring the use of drawings, interviews and rating-scales with children aged 6-7 years. *Journal of Occupational Science, 18*(4), 306-321. doi: 10.1080/14427591.2011.586323

Minkowski, E. (1927). *La schizophrenie.* Paris: Editions Payot & Rivages.

Minkowski, E. (1948). *Phenomenologie et analyse existentielle en psychopathologie. Reprint of courses given at the College Philosophique, Paris*. Paris: PUF.

Mitchell, A. J. (2004). Early intervention for first episode psychosis~Worldwide burden of psychosis is not as severe as suggested [Letter]. *British Medical Journal, 329*, 401.

Møller, P. (2001). Duration of untreated psychosis: Are we ignoring the mode of initial development? An extensive naturalistic case study of phenomenal continuity in first-episode schizophrenia. *Psychopathology, 34*, 8-14.

Monti, M. R. (2005). New interpretive style: Progress or contamination? Psychoanalysis and phenomenological psychopathology. *International Journal of Psychoanalysis, 86*, 1011-1032.

Morgan, C., Charalambides, M., Hutchinson, G., & Murray, R. M. (2010). Migration, ethnicity, and psychosis: Toward a sociodevelopmental model. *Schizophrenia Bulletin, 36*(4), 655-664. doi: 10.1093/schbul/sbq051

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research, 1*(1), 48-76. doi: 10.1177/2345678906292462

Mosey, A. (1970). *Three frames of reference for mental health*. Thorofare, NJ: Slack, Inc.

Mosey, A. (1986). *Psychosocial components of occupational therapy*. New York, NY: Raven.

Moules, N. J., Field, J. C., McCaffery, G. P., & Laing, C. M. (2014). Conducting hermeneutic research: The address of the topic. *Journal of Applied Hermeneutics, 4*. http://jah.journalhosting.ucalgary.ca/jah/index.php/jah/article/view/66

Mullen, P. E. (2007). A modest proposal for another phenomenological approach to psychopathology. *Schizophr Bull, 33*(1), 113-121. doi: 10.1093/schbul/sbl043

Mundt, C. (2005). Anomalous self-experience: A plea for phenomenology. *Psychopathology, 38*(5), 231-235. doi: 10.1159/000088440

Murray, H. A., & Morgan, C. D. (1938). *Explorations in personality*. New York, NY: Oxford University Press.

Napoli, P. J. (1951). Finger painting. In H. H. Andersen & G. L. Andersen (Eds.), *An introduction to projective techniques and other devices for understanding the dynamics of human behavior* (pp. 386-415). Englewood Cliffs, NJ: Prentice-Hall, Inc.

Nelson, B., Sass, L. A., & Skodlar, B. (2009). The phenomenological model of psychotic vulnerability and its possible implications for psychological interventions in the ultra-high risk ('prodromal') population. *Psychopathology, 42*(5), 283-292. doi: 10.1159/000228837

Nelson, B., Yuen, K., & Yung, A. R. (2011). Ultra high risk (UHR) for psychosis criteria: Are there different levels of risk for transition into psychosis? *Schizophrenia Research, 125*(1), 62-68. doi: 10.1016/j.schres.2010.10.017

Nelson, B., & Yung, A. R. (2011). Should a risk syndrome for first episode psychosis be included in the DSM-5? *Current Opinion in Psychiatry, 24*(2), 128-133.

Nelson, B., Yung, A. R., Bechdolf, A., & McGorry, P. D. (2008). The phenomenological critique and self-disturbance: implications for ultra-high risk ("prodrome") research. *Schizophrenia Bulletin, 34*(2), 381-392. doi: 10.1093/schbul/sbm094

Nicholls, L., Cunningham Piergrossi, J., de Sena Gibertoni, C., & Daniel, M. (2013). *Psychoanalytic thinking in occupational therapy*. Oxford, UK: Wiley-Blackwell.

Noe, A. (2000). Experience and experiment in art. *Journal of Consciousness Studies, 7*(8-9), 123-135.

Nolin, M., Malla, A., Tibbo, P., Norman, R., & Abdel-Baki, A. (2016). Early intervention for psychosis in Canada. What is the state of affairs? . *Canadian Journal of Psychiatry, 61*(3), 186-194.

Nuechterlein, K., & Dawson, M. E. (1984). A heuristic vulnerability-stress model of schizophrenia. *Schizophrenia Bulletin, 10*, 300-312.

O'Hagan, M. (2009). Leadership for empowerment and equality: A proposed model for mental health user/survivor leadership. *The International Journal of Leadership in Public Services, 5*(4), 34-43.

Ochoa, S., Usall, J., Cobo, J., Labad, X., & Kulkarni, J. (2012). Gender differences in schizophrenia and first-episode psychosis: A comprehensive literature review. *Schizophrenia Research and Treatment, 2012*, 916198. doi: 10.1155/2012/916198

Office of Professional Orders in Quebec. (2013). *Guide explicatif du PL no 21 (Guide to Bill 21).* Quebec City, QC, Canada: Quebec Government Retrieved from http://www.opq.gouv.qc.ca/actualites/communiques/detail/article/pl-21-mise-a-jour-du-guide-explicatif/.

Ogdon, D. O. (1977). *Psychodiagnosis and personality assessment: A handbook* (2nd ed.). Los Angeles, CA: Western Psychological Services.

Okumu, J. (2007). Personal identity, projects, and morality in Bernard Williams' earlier writings. *Ethical Perspectives, 14*(1), 13-27. doi: 10.2143/ep.14.1.2021810

Ordre des Ergothérapeutes du Quebec. (2015). Réflexion sur les répercussions du DSM-5 sur la pratique des ergothérapeutes du Québec. *Ergothérapie Express. Le bulletin de l'Ordre des ergothérapeutes du Québec, 26*(3), 3. https://www.oeq.org/userfiles/File/Publications/Ergotherapie_express/2015_Septembre.pdf

Papadimitriou, C., Magasi, S., & Frank, G. (2012). Current thinking in qualitative research: Evidence-based practice, moral philosophies, and political struggle. *Occupational Therapy Journal of Research: Occupation, Participation and Health, 32*(Suppl. 1), S2-S5. doi: doi:10.3928/15394492-20111005-01

Park Lala, A., & Kinsella, E. A. (2011a). Embodiment in research practices. In H. J., A. Titchen, D. Hirsfall & D. Bridges (Eds.), *Creative spaces for qualitative researching: Living research* (pp. 77-86). Rotterdam, The Netherlands: Sense Publishers.

Park Lala, A., & Kinsella, E. A. (2011b). Phenomenology and the study of human occupation. *Journal of Occupational Science, 18*(3), 195-209. doi: 10.1080/14427591.2011.581629

Park, M. (2012). Pleasure, throwing breaches, and embodied metaphors: Tracing transformations-in-participation for a child with autism to a sensory integration-based therapy session. *Occupational Therapy Journal of Research: Occupation, Participation and Health, 32*(1S), S34-S47.

Parker, S., & Lewis, S. (2006). Identification of young people at risk of psychosis. *Advances in Psychiatric Treatment, 12*, 249-255.

Parnas, J. (2000). The self and intentionality in the pre-psychotic stages of schizophrenia. In D. Zahavi (Ed.), *Exploring the self: Philosophical and psychopathological perspectives on self-experience* (pp. 115-147). Amsterdam, The Netherlands: John Benjamins Publishing Company.

Parnas, J. (2011). A disappearing heritage: the clinical core of schizophrenia. *Schizophrenia Bulletin, 37*(6), 1121-1130. doi: 10.1093/schbul/sbr081

Parnas, J., Handest, P., Sæbye, D., & Jansson, L. (2003). Anomalies of subjective experience in schizophrenia and psychotic bipolar illness. *Acta Psychiatrica Scandinavica, 108*, 126-133.

Parnas, J., Moller, P., Kircher, T., Thalbitzer, J., Jansson, L., Handest, P., & Zahavi, D. (2005). EASE: Examination of Anomalous Self-Experience. *Psychopathology, 38*(5), 236-258. doi: 10.1159/000088441

Parnas, J., Sass, L. A., & Zahavi, D. (2011). Phenomenology and psychopathology. *Philosophy, Psychiatry, & Psychology, 18*(1), 37-39.

Patton, M. Q. (1990). *Qualitative research and evaluation methods* (2nd ed.). Newbury Park, CA: Sage.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Peloquin, S. M. (1989). Sustaining the art of practice in occupational therapy. *American Journal of Occupational Therapy, 43*(4), 219-226.

PEPP. (2014). Prevention and Early Intervention Program for Psychoses - Early recognition of psychosis. Retrieved April 30, 2014, from http://www.pepp.ca/recogn5.html

Perruzza, N., & Kinsella, E. A. (2010). Creative arts occupations in therapeutic practice: A review of the literature. *British Journal of Occupational Therapy, 73*(6), 261-268.

Perry, B. M., Taylor, D., & Shaw, S. K. (2007). "You've got to have a positive state of mind": An interpretative phenomenological analysis of hope and first episode psychosis. *Journal of Mental Health, 16*(6), 781-793. doi: 10.1080/09638230701496360

Peters, C. O. (2011). Powerful occupational therapists: A community of professionals, 1950–1980. *Occupational Therapy in Mental Health, 27*(3-4), 199-410. doi: 10.1080/0164212x.2011.597328

Petrova, M., Dale, J., & Fulford, B. K. (2006). Values-based practice in primary care: Easing the tensions between individual values, ethical principles and best evidence. *Journal of General Practice* (56), 703-709.

Phelan, S. K. (2011). Constructions of disability: A call for critical reflexivity in occupational therapy. *Canadian Journal of Occupational Therapy, 78*(3), 164-172. doi: 10.2182/cjot.2011.78.3.4

Phelan, S. K., & Kinsella, E. A. (2009). Occupational identity: Engaging socio‐cultural perspectives. *Journal of Occupational Science, 16*(2), 85-91. doi: 10.1080/14427591.2009.9686647

Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., . . . Zachar, P. (2012). The six most essential questions in psychiatric diagnosis: A pluralogue. Part 1: Conceptual and definitional issues in psychiatric diagnosis. *Philosophy, Ethics, and Humanities in Medicine 7*, 3. doi: 10.1186/1747-5341-7-3

Piotrowski, C. (1984). The status of projective techniques: Or, "wishing won't make it go away." *Journal of Clinical Psychology, 40*, 1495-1502.

Piotrowski, C., Keller, J. W., & Ogawa, T. (1993). Projective techniques: An international perspective. *Psychological Reports, 72*, 179-182.

Polatajko, H., & Kaiserman, E. (1986). House-Tree-Person projective technique: A validation of its use in occupational therapy. *Canadian Journal of Occupational Therapy, 53*, 197-207.

Raballo, A., & Parnas, J. (2012). Examination of anomalous self-experience: Initial study of the structure of self-disorders in schizophrenia spectrum. *Journal of Nervous and Mental Disease, 200*(7), 577-583.

Rabin, A. I. (1981). Projective methods: A historical introduction. In A. I. Rabin (Ed.), *Assessment with projective techniques: A concise introduction* (pp. 1-22). New York, NY: Springer.

Rahm, C., & Cullberg, J. (2007). Diagnostic stability over 3 years in a total group of first-episode psychosis patients. *Nordic Journal of Psychiatry, 61*(3), 189-193. doi: 10.1080/08039480701352454

Ramirez, N., Arranz, B., Salavert, J., Alvarez, E., Corripio, I., Duenas, R. M., . . . San, L. (2010). Predictors of schizophrenia in patients with a first episode of psychosis. *Psychiatry Research, 175*(1-2), 11-14. doi: 10.1016/j.psychres.2009.03.013

Rapado-Castro, M., Soutullo, C., Fraguas, D., Arango, C., Payá, B., Castro-Fornieles, J., . . . Bombin, I. (2010). Predominance of symptoms over time in early-onset psychosis: A principal component factor analysis of the Positive and Negative Syndrome Scale. *Journal of Clinical Psychiatry, 71*(3), 327-337. doi: 10.4088/JCP.08m04845yel.

Rapaport, D., Gill, M. M., & Schafer, R. (1968). *Diagnostic psychological testing, revised edition*. New York, NY: International Universities Press Inc.

Raskin, J. D. (2001). Constructivism and the projective assessment of meaning in Rorschach administration. *Journal of Personality Assessment, 77*(1), 139-161.

Rassafiani, M., Ziviani, J., Rodger, S., & Dalgleish, L. (2009). Identification of occupational therapy clinical expertise: Decision-making characteristics. *Australian Occupational Therapy Journal 56*(3), 156-166. doi: 10.1111/j.1440-1630.2007.00718.x

Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*(5), 330-350. doi: 10.1111/j.1600-0447.2005.00634.x

Reed, K. (2011). Exploring the meaning of occupation: The case for phenomenology. *Canadian Journal of Occupational Therapy, 78*(5), 303-310. doi: 10.2182/cjot.2011.78.5.5

Reed, K., Hocking, C., & Smythe, L. (2010). The interconnected meanings of occupation: The call, being - with, possibilities. *Journal of Occupational Science, 17*(3), 140-149. doi: 10.1080/14427591.2010.9686688

Restall, G., & Ripat, J. (2008). Applicability and clinical utility of the Client-Centred Strategies Framework. *Canadian Journal of Occupational Therapy, 75*(5), 288-300.

Reynolds, F. (2008). Expressive media used as assessment in mental health. In B. Hemphill-Pearson, J. (Ed.), *Assessments in occupational therapy mental health. An integrative approach* (2nd ed., pp. 81-96). Thorofare, NJ: Slack Inc.

Rhéaume, J. (Ed.). (2006). *Espace de réflexion, espace d'action en santé mentale au travail. Enquêtes en psychodynamique du travail au Québec. (A space for reflection, a place for action in workplace mental health. Studies on the psychodynamics of work in Quebec).* Quebec City, QC, Canada: Presses de l'Université Laval (University of Laval).

Ricoeur, P. (1974). *The conflict of interpretations: Essays in hermeneutics.* Evanston, IL: Northwest University Press.

Ricoeur, P. (1977). *The rule of metaphor. The creation of meaning in language*. Toronto, ON: University of Toronto Press.

Ricoeur, P. (2002). Narrative time. In B. Richardson (Ed.), *Narrative dynamics: Essays on time, plots, closure, and frames* (pp. 35-46). Columbus, OH: Ohio State University Press.

Ritzler, B. (1995). Putting your eggs in the content analysis basket: A response to Aronow, Reznikoff, and Moreland. *Journal of Personality Assessment, 64*, 229-234.

Rorschach, H. (1921). *Psychodiagnostik (Psychodiagnostics)*. Berne, Switzerland: Ernst Bircher Verlag.

Rossman, R. B., & Rallis, S. F. (1998). *Learning in the field: An introduction to qualitative research.* Thousand Oaks, CA: Sage.

Roy, L., Rousseau, J., Fortier, P., & Mottard, J. P. (2013). Housing and home-leaving experiences of young adults with psychotic disorders: A qualitative comparative study. *Community Mental Health Journal, 49*(5), 515-527.

Rulf, S. (2003). Phenomenological contributions on schizophrenia: A critical review and commentary on the literature between 1980-2000. *Journal of Phenomenological Psychology, 34*, 1.

Rushdie, S. (1981). *Midnight's children.* Toronto, ON: Vintage Canada

Rushdie, S. (1990). *Haroun and the Sea of Stories*. London, UK: Granta Books.

Rushdie, S. (1999). *The ground beneath her feet.* Toronto, ON: Vintage Canada.

Rushdie, S. (2010). *Luka and the Fire of Life*. Toronto, ON: Alfred A. Knopf Canada.

Saint-Jean, M., & Desrosiers, L. (1993). Psychoanalytic considerations regarding the occupational therapy setting for the treatment of the psychotic patient. *Occupational Therapy in Mental Health, 12*(2), 69-78.

Saks, E. R. (2007). *The center cannot hold: My journey through madness*. New York, NY: Hyperion.

Sandelowski, M., Voils, C. I., & Knafl, G. (2009). On Quantitizing. *Journal of Mixed Methods Research, 3*(3), 208-222. doi: 10.1177/1558689809334210

Sass, L. A., & Parnas, J. (2001). Phenomenology of self-disturbances in schizophrenia: Some research findings and directions. *Philosophy, Psychiatry, & Psychology, 8*(4), 347-356. doi: 10.1353/ppp.2002.0027

Sass, L. A., Parnas, J., & Zahavi, D. (2011). Phenomenological psychopathology and schizophrenia: Contemporary approaches and misunderstandings. *Philosophy, Psychiatry, & Psychology, 18*(1), 1-23.

Schmid, T. (2004). Meanings of creativity within occupational therapy practice. *Australian Occupational Therapy Journal, 51*, 80-88.

Schmidt, L. D., & McGowan, J. F. (1959). The differentiation of human figure drawings. *Journal of Consulting Psychology, 23*, 129-133.

Schultze-Lutter, F., Ruhrmann, S., Picker, H., von Reventlow, H. G., Brockhaus-Dumke, A., & Klosterkotter, J. (2007). Basic symptoms in early psychotic and depressive disorders. *British Journal of Psychiatry. Supplement, 51*, s31-37. doi: 10.1192/bjp.191.51.s31

Shaw, K., McFarlane, A. C., Bookless, C., & Air, T. (2002). The aetiology of postpsychotic posttraumatic stress disorder following a psychotic episode. *Journal of Traumatic Stress, 15*(1), 39-47.

Sheffer, M., & Harlock, S. (1980). The use of drawings in occupational therapy patient-evaluations. *Journal of Rehabilitation, 46*, 44-49.

Shephard, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality.* London, UK: Sainsbury Centre for Mental Health.

Shoemyen, C. W. (1970). A study of procedure and media in occupational therapy orientation and evaluation. *American Journal of Occupational Therapy, XXIV*(4), 276-279.

Singer, J. L. (1981). Research applications of projective methods. In A. I. Rabin (Ed.), *Assessment with projective techniques: A concise introduction* (pp. 297-331). New York, NY: Springer.

Slade, M. (2009). *100 ways to support recovery: A guide for mental health professionals* In Rethink (Series Ed.) Vol. 1. *Rethink Recovery Series* (pp. 32). Retrieved from http://www.rethink.org/100ways

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis. Theory, method and research.* Thousand Oaks, CA: SAGE Publications.

Stanghellini, G. (2007). The grammar of the psychiatric interview. A plea for the second-person mode of understanding. *Psychopathology, 40*(2), 69-74. doi: 10.1159/000098486

Stanghellini, G. (2010). A hermeneutic framework for psychopathology. *Psychopathology, 43*(5), 319-326. doi: 10.1159/000319401

Stanghellini, G. (2011). Clinical phenomenology: A method for care? *Philosophy, Psychiatry, & Psychology, 18*(1), 25-29.

Stanghellini, G., & Ballerini, M. (2007). Values in persons with schizophrenia. *Schizophrenia Bulletin, 33*(1), 131-141. doi: 10.1093/schbul/sbl036

Statistics Canada. (2006). Immigration in Canada: A portrait of the foreign-born population, 2006 Census: Portraits of major metropolitan centres. Retrieved September 23, 2013, from http://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-557/p29-eng.cfm

Stern, D. N. (1985). *The interpersonal world of the infant. A view from psychoanalysis and developmental psychology*. New York, NY: Basic Books.

Steward, B. (1996). Creative therapies. In M. Willson (Ed.), *Occupational therapy in short term psychiatry* (2nd ed., pp. 173-194). Edinburgh, Scotland: Churchill Livingstone.

Streiner, G. R., & Norman, D. L. (2008). *Health measurement scales, a practical guide to their development and use* (4th ed.). Oxford, UK: Oxford University Press.

Sullivan, H. S. (1927). The onset of schizophrenia. *American Journal of Psychiatry, 6*, 105-134.

Sumsion, T. (2005). Facilitating client-centred practice: Insights from clients. *Canadian Journal of Occupational Therapy, 72*(1), 13-20.

Sumsion, T., & Law, M. C. (2006). A review of evidence on the conceptual elements informing client-centred practice. *Canadian Journal of Occupational Therapy, 73*(3), 153-162.

Sutton, D. J., Hocking, C. S., & Smythe, L. A. (2012). A phenomenological study of occupational engagement in recovery from mental illness. *Canadian Journal of Occupational Therapy, 79*(3), 142-150. doi: 10.2182/cjot.2012.79.3.3

Szondi, L., Moser, U., & Webb, M. W. (1959). *The Szondi test: In diagnosis, prognosis and treatment*. Philadelphia, PA: Lippincott.

Tallant, B. K. (1966). The uses of blind and non-blind occupational therapy test batteries as an aid to diagnosis. . In J. J. Lopez Ibor (Ed.), *Proceedings Fourth World Congress of Psychiatry* (pp. 2661-2662). Madrid, Spain: Excerpta Medica.

Tallant, B. K. (2002). Assessment of performance-Section I: Projective assessments [Coursepack for McGill University Course 580-341B]. Montreal, QC, Canada: Eastman Systems Inc.

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research ~ Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Thousand Oaks, CA: Sage Publications.

Thompson, M., & Blair, S. E. E. (1998). Creative arts in occupational therapy: Ancient history or contemporary practice? *Occupational Therapy International, 5*(1), 48-64.

Thornton, T., & Lucas, P. (2011). Paper: On the very idea of a recovery model for mental health. *Journal of Medical Ethics, 37*(January), 24-28.

Tranulis, C., Zafran, H., Whitley, R., & Park, M. (2011). The first episode psychosis movement: An ethnography of new hopes to untangle stigma and psychosis. (Vol. 100'000$). Montreal, QC: Canadian Institutes of Health Research.

Unsworth, C. A. (2005). Using a head-mounted video camera to explore current conceptualizations of clinical reasoning in occupational therapy. *American Journal of Occupational Therapy, 59*(1), 31-40.

Urfer, A. (2001). Phenomenology and psychopathology of schizophrenia: The views of Eugene Minkowski. *Philosophy, Psychiatry & Psychology, 8*(4), 279-289. doi: 10.1353/ppp.2002.0029

Van Ness, P. H., Fried, T. R., & Gill, T. M. (2011). Mixed methods for the interpretation of longitudinal gerontologic data: Insights from philosophical hermeneutics. *Journal of Mixed Methods Research, 5*(4), 293-308. doi: 10.1177/1558689811412973

van Nimwegen, L., de Haan, L., van Beveren, N., Laan, W., van den Brink, W., & Linszen, D. (2008). Obsessive-compulsive symptoms in a randomized, double-blind study with olanzapine or risperidone in young patients with early psychosis. *Journal of Clinical Psychopharmacology, 28*(2), 214-218.

Vogel, R., Hanke, C., Miller, H., & Smith, I. (1950). Finger painting techniques at Ypsilanti state hospital. *American Journal of Occupational Therapy, 4*, 100-101.

von Zweck, C., Paterson, M., & Pentland, W. (2008). The use of hermeneutics in a mixed methods design. *The Qualitative Report, 13*(1), 116-134.

Weber, S. (2008). Visual images in research. In J. G. Knowles & A. L. Cole (Eds.), *Handbook of the Arts in Qualitative Research*. Thousand Oaks, CA: Sage Publications

Weil, K. (2009). *Bill n°21 : An act to amend the professional code and other legislative provisions in the field of mental health and human relations*. Quebec City, QC, Canada: Assemblée Nationale du Quebec (National Assembly of Quebec).

Weiner, I. B. (1966). *Psychodiagnosis in schizophrenia*. New York, NY: John Wiley.

Weininger, D. L. (1999). Hermeneutics and phenomenology - A lecture by David Weininger. Retrieved May 12, 2014, from http://people.bu.edu/WWILDMAN/WeirdWildWeb/courses/wphil/lectures/wphil_theme19.htm - Weininger%20H%20and%20P

Weinroth, L. A. (1955). Dynamic occupational therapy. *American Journal of Occupational Therapy, IX*(5), 243.

Weinstein, E. (1998). Elements of the art of practice in mental health. *American Journal of Occupational Therapy, 52*(7), 579-585.

Wenck, L. S. (1970). *House-Tree-Person drawings: An illustrated diagnostic handbook*. Torrance, CA: Western Psychological Services.

West, W., L. (1959). *Changing concepts and practices in psychiatric occupational therapy*. Paper presented at the American Occupational Therapy Association: Function and preparation of the psychiatric occupational therapist, Boiling Springs, Pennsylvania.

Whitley, R. (2010). Rediscovering hope. *Psychiatric Rehabilitation Journal, 33*(3), 239-241. doi: 10.2975/33.3.2010.239.241

Wikipedia. (2014, April 14, 2014). Ragtime. Retrieved March 23, 2014, from http://en.wikipedia.org/wiki/Ragtime

Wilcock, A. A. (1998). Reflections on doing, being, and becoming. *Canadian Journal of Occupational Therapy, 65*(5), 248-257.

Wilding, C., & Whiteford, G. (2007). Occupation and occupational therapy: Knowledge paradigms and everyday practice. *Australian Occupational Therapy Journal, 54*(3), 185-193. doi: 10.1111/j.1440-1630.2006.00621.x

Williams, C. C. (2008). Insight, stigma and post-diagnosis identities in schizophrenia. *Psychiatry: The Journal of Interpersonal and Biological Processes, 71*(3), 246-235.

Winters, N. C., Hanson, G., & Stoyanova, V. (2007). The case formulation in child and adolescent psychiatry. *Child and Adolescent Psychiatric Clinics of North America, 16*(1), 111-132, ix. doi: 10.1016/j.chc.2006.07.010

Wittkower, E. D., & Azima, H. (1958). Dynamic aspects of occupational therapy. *Archive of Neurological Psychiatry, 79*(6), 706-710. doi: 10.1001/archneurpsyc.1958.02340060104014.

Woodside, H., Krupa, T., & Pocock, K. (2007). Early psychosis, activity performance and social participation: A conceptual model to guide rehabilitation and recovery. *Psychiatric Rehabilitation Journal, 31*, 125-130.

World Health Organisation. (2001). *The World Health Report, 2001: Mental Health: New Understanding, New Hope*. Geneva: World Health Organisation.

World Health Organisation. (2010). *Empowerment in mental health - Working together towards leadership*. Paper presented at the WHO Regional Office for Europe: Empowerment in mental health - Working together towards leadership. A meeting in partnership with the European Commission, Leuven, Belgium.

World Health Organization. (2001). The World Health Report, 2001: Mental Health: New Understanding, New Hope. Geneva: World Health Organization.

World Health Organization. (2012). Development of a global mental health action plan 2013-2020. Retrieved February 18, 2014, from http://www.who.int/mental_health/mhgap/consultation_global_mh_action_plan_2013_2020/en/index.html

Yakobina, S., Yakobina, S., & Tallant, B. K. (1998). I came, I thought, I conquered. *Occupational Therapy in Mental Health, 13*(4), 59-73. doi: 10.1300/J004v13n04_04

Yang, L. H., Wonpat-Borja, A. J., Opler, M. G., & Corcoran, C. M. (2010). Potential stigma associated with inclusion of the psychosis risk syndrome in the DSM-V: An empirical question. *Schizophrenia Research, 120*(1-3), 42-48.

Yerxa, E. (1993). Occupational science: A new source of power for participants in occupational therapy. *Journal of Occupational Science, 1*, 3-9.

Yung, A. R., & McGorry, P. D. (1996). The prodromal phase of first-episode psychosis: Past and current conceptualizations. *Schizophrenia Bulletin, 22*(2), 353-370.

Yung, A. R., McGorry, P. D., McFarlane, C. A., Jackson, H. J., Patton, G. C., & Rakkar, A. (1996). Monitoring and care of young people at incipient risk of psychosis. *Schizophrenia Bulletin, 22*(2), 283-303.

Yung, A. R., Woods, S. W., Ruhrmann, S., Addington, J., Schultze-Lutter, F., Cornblatt, B. A., . . . McGlashan, T. H. (2012). Whither the attenuated psychosis syndrome? *Schizophrenia Bulletin, 38*(6), 1130-1134. doi: 10.1093/schbul/sbs108

Yung, A. R., Yuen, H. P., McGorry, P. D., Phillips, L. J., Kelly, D., Dell'Olio, M., . . . Buckby, J. (2005). Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States. *Australian and New Zealand Journal of Psychiatry, 39*(11-12), 964-971.

Zafran, H. (2015). Health care professional's opinions on culture and rehabilitation services for youth experiencing early psychosis. *International Journal of Psychosocial Rehabilitation, 19*(2), 75-82.

Zafran, H., & Laporta, M. (2008). *What are the key ingredients in early psychosis intervention? Program evaluation of a Montreal initiative: 1997-2007*. Paper presented at the 6th International Conference on Early Psychosis, Melbourne, Australia.

Zafran, H., & Park, M. M. (Submitted). View from the penthouse. Illustrating hermeneutic reflexive analytic strategies for rigorous interdisciplinary research. *Ethos*.

Zafran, H., & Tallant, B. K. (2015a). "It would be a shame to lose them" ~ A critical historical, scoping, and expert review on the use of projective assessments in occupational therapy. Part I. *Occupational Therapy in Mental Health, 33*(3), 187-210. doi: 10.1080/0164212X.2015.1065538

Zafran, H., & Tallant, B. K. (2015b). "It would be a shame to lose them" ~ A critical historical, scoping, and expert review on the use of projective assessments in occupational therapy. Part II. *Occupational Therapy in Mental Health, 33*(4), 328-365.

Zafran, H., Tallant, B. K., & Gelinas, I. (2012). The experience of academic reintegration after a first episode of psychosis - A first-person exploration. *International Journal of Psychosocial Rehabilitation, 16*(1), 27-43.

Zahavi, D. (2005). *Subjectivity and selfhood. Investigating the first-person perspective.* Cambridge, MA: The MIT Press.

Zandi, T., Havenaar, J. M., Laan, W., Kahn, R. S., & van den Brink, W. (2011). Predictive validity of a culturally informed diagnosis of schizophrenia: A 30 month follow-up study with first episode psychosis. *Schizophrenia Research, 133*(1-3), 29-35. doi: 10.1016/j.schres.2011.09.024

Appendix 1: Psychiatrist invitation to participate in recruitment

Dear Dr. _____
Thank you for your kind email agreeing to participate in a research project exploring the use of an occupational therapy evaluation with young adults seeking help for pre/first episode psychosis. Your support is greatly appreciated. Please find the following in this package:

- A brief description of the project, which has been approved by the McGill Institutional Review Board for your site. The summary describes the purpose of the study, participant criteria, and referral process.
- A form for your signature, which would be considered a signed agreement to collaborate in the identification and recruitment of potential research participants for the doctoral research project: *"The clinical use of an expressive projective test with help-seeking youth: A mixed methods inquiry into elicited narratives and patterns of performance"*. If you choose to participate, please return the signed form to the coordinates below.
- Several Consent to Communicate Forms for use with willing potential participants

The researcher is Hiba Zafran, doctoral candidate, under the supervision of Dr. Isabelle Gelinas (Principal Investigator) and Dr. Beverlea Tallant. The proposed research entails a one-time, videotaped, occupational therapy evaluation focused on exploring the participant's subjective experience. The research participant's consent would include access to their medical chart. A clinical report of the evaluation results will be shared with you.

Thank you for your willingness to facilitate this project,

Respectfully,

Hiba Zafran, MSc., Erg.
PhD Rehabilitation Sciences candidate
School of Physical and Occupational Therapy, McGill University
Clinic: 514.934.1934 x34168
McGill: 514.398.4400 x09641
Email: hiba.zafran@mcgill.ca

1025 Ave des Pins West
Allan Memorial Institute
Occupational Therapy Dept: P2.168

Montreal, QC
H3A 1A1

or

3654 Promenade Sir William Osler
School of Physical and
Occupational Therapy
Hosmer House, H201
Montreal, QC
H3G 1Y5

Appendix 2: Psychiatrist's agreement to participate

Date: _____

Date: _____

I, Dr. _____, am willing to aid Hiba Zafran, PhD candidate, in identifying, informing and inviting potential participants for the project entitled: "*The clinical use of an expressive projective test with help-seeking youth: A mixed methods inquiry into elicited narratives and patterns of performance*".

This includes agreement with the following:

(1) Being aware of the research inclusion criteria (attached)
(2) Using the Consent to Communicate Form with potential participants (copies and envelopes provided)
(3) **NOT** informing the researcher (H. Zafran) of any diagnostic or clinical impressions of the potential participant

Signature: _____

Preferred contact information: _____

Your collaboration is greatly valued

Any questions or clarifications can be addressed to:
Hiba Zafran or Dr. Isabelle Gelinas (Principal Investigator) at the following coordinates:

Clinic: 514.934.1934 x34168
McGill: 514.398.4400 x09641 514.398.3514

Email: hiba.zafran@mcgill.ca isabelle.gelinas@mcgill.ca

Appendix 3: Project summary and criteria for recruitment

The clinical use of an expressive projective test with help-seeking youth:
A mixed methods inquiry into elicited narratives and patterns of performance

H.Zafran, PhD Candidate

Efforts to identify and accurately diagnose youth with incipient psychosis are critical in order to prevent the onset of disability and handicap. Research demonstrates that difficulties in self-experience and activity performance emerge prior to the overt signs of psychosis onset. Occupational therapists can elicit a first-person narrative of lived experience, and observe latent performance deficits, through the use of expressive projective evaluations. This is especially useful when engaging with persons who have difficulty communicating their experience due to their developmental stage or emergent difficulties in thinking.

The overall objective of this research study is to explore and refine the analysis and interpretation process of the Azima Occupational Therapy Battery when used specifically with youth within the range of pre – to – first episode of psychosis. For the consenting participant, this entails a one-time, videotaped, occupational therapy evaluation session of approximately two hours which will take place in the occupational therapy department of the Allan Memorial Institute. Participants will be offered a *15$* flat fee as compensation for travel expenses. A sample of 30 is aimed for. You will be informed when the one-year recruitment process is completed.

Inclusion criteria

All participants are expected to be comfortable in English or French, and able to provide written consent.

Help-seeking youth aged **18-25,** demonstrating signs and symptoms of pre-to-first time psychosis as determined by a psychiatrist and/or diagnosed with an as yet unremitted first episode psychosis by **at least one** of the following criteria:

- Brief Limited Intermittent Psychotic Symptoms (BLIPS) occurring for less than 1 week
- A decline in psychosocial functioning and a first-degree relative with a psychotic-spectrum diagnosis
- A decline in psychosocial functioning and several second-degree relatives with a psychotic-spectrum diagnosis
- Prepsychotic features as assessed by an appropriate psychiatric measure (e.g. a psychiatric interview, or a rating scale such as the Clinical Assessment of At Risk Mental Status)
- Diagnosis has been made by a psychiatrist-led diagnostic interview based on DSM-IV-R criteria Differential diagnoses may include any of the following:
    a. Drug-induced psychosis
    b. Psychosis Not Otherwise Specified (NOS)/Not Yet Diagnosed (NYD)
    c. Brief Psychotic Episode
    d. Schizophreniform
    e. First episode schizophrenia/schizo-affective
    f. Psychotic depression
    g. First episode mania with psychotic features
    h. Rule out personality disorders with micro-psychotic features

Exclusion criteria

- Psychotic features secondary to a neurological process such as epilepsy, meningitis, concussion, brain tumour or other severe traumatic brain injury or disease
- In symptomatic and functional remission from psychosis
- Experiencing a second or more episode of psychosis
- Co-morbidity with severe intellectual handicap (IQ <70 as per psychological testing)
- Persons only transitioning in the Montreal region (i.e. no local residence)
- Homeless persons refusing clinical services for housing
- Not comfortable speaking either English or French
- Not currently followed by an attending psychiatrist

The following is a suggested statement that could be used to explain the research project to potential participants.

"Sometimes it is hard to explain what is wrong, what is difficult, and how or why doing regular things has become a significant challenge. An occupational therapist at McGill University is conducting a research project looking at using a specific occupational therapy evaluation as a way to better understand young adults' experiences, such as yours."

They can then be invited to read and complete the Consent to Communicate Form to be informed further of the project. Signing the form does not imply actual participation in the research project.

Your support of this study is greatly appreciated

Appendix 4: Consent for Communication

Name: _____

Telephone: _____

Researchers at McGill University are interested in the use of a specific occupational therapy evaluation as a way to better understand young adults' experiences. This would involve a one-time evaluation session with a McGill researcher from the School of Physical and Occupational Therapy.

Signing this form only indicates a willingness to be contacted by the researcher – Hiba Zafran – who will explain the project more fully to you. It does not mean that you have to take part in the research. You may ask questions of the researcher and may contact her at the coordinates below. You may withdraw from this agreement at anytime without prejudice to yourself. Your contact information will remain confidential and anonymous.

"I agree to allow the designated researcher to call me to discuss this project more fully"

Signature: _____

Date: _____

Appropriate times to call: _____

Hiba Zafran, Occupational Therapist
PhD Rehabilitation Sciences candidate
McGill University Health Centre (514) 934-1934 Ext. 34168

Principal Investigator: Isabelle Gelinas, PhD., O.T. (C) (514) 398.4514

Appendix 5: Medical Chart Data Extraction Form

Research CODE:

Medical Chart Number:

Date of Birth:

Attending Psychiatrist's Primary Diagnosis at Intake (Date):

AOTB Impression (Date):

Attending Psychiatrist's Primary Diagnosis at One Year or more (Date):

Following Info to be Obtained at INTAKE date

Prescribed medications at intake:

Documented effects of medications at intake:

Duration of Untreated Psychosis *(if applicable)*

History of drug use

Legal:

OCCUPATIONAL PROFILE

Education
Educational level:

Formal artistic training: 0 Yes 0 No (if yes, include available details)

Born in Canada: 0 Yes 0 No

If Yes, parents born in Canada? If No, born in: _____
0 Yes

0 No, parent(s) were born in: _____Age arrived in Canada: _____

Adverse Life Events (incl Family psych Hx)

Sexuality/intimate Relationships

Living Arrangements:

0 With family members
0 Alone
0 With roommates
0 Supervised apartment
0 Group home

Source of Income **(check all that apply):**

0 Part-time job → Number of hours / week: _____
0 Full-time job → Number of hours / week: _____
Job description: _____

0 Parents or family
0 On the poverty Line
0 Personal savings
0 Emploi-Quebec program
0 Student loans and bursaries

0 Academic scholarship

0 Welfare *Specify since when* _____

0 Other _____

Occupations **(check all that apply):**

0 School part-time → Number of courses: _____

0 School full-time → Number of courses: _____

School & Program: _____

0 Mainly activities on own, spend sa lot of time at home

0 Main socialization is with my family

0 The people seen the most are clinicians

0 Has friends to spend time with every week

0 Participates regularly in organized activities e.g. church, extended family

0 Participates in leisure/sports activities regularly

Leisure activities: **(check all that apply):**

0 Solitary activities

0 Solitary sport

0 Sport with partner

0 Team sport

0 Exercise class

0 Games with family / friends

0 Faith-based organized activities

0 School based club

0 Movies with family / friends

0 Movies alone

Provide a descriptive summary of the individual's occupational outcomes upon discharge / most recent date

Thank you for engaging with this work.

Hiba Zafran, PhD.
Occupational Therapist – Psychotherapist

April 9th, 2016

Montreal, QC
Canada